

Exhibit A
to
Commissioner's Order No. G 03-98

**COMBINED MARKET CONDUCT AND
FINANCIAL EXAMINATION**

**WASHINGTON STATE HEALTH INSURANCE
POOL**

**P. O. BOX 269
BOW, WA 98232-0269**

January 1, 2001 – June 30, 2002



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The Honorable Mike Kreidler
Washington State Insurance Commissioner
Insurance Building
P.O. Box 40255
Olympia, Washington 98504

Dear Commissioner Kreidler:

Pursuant to your instructions and in compliance with the statutory requirements of RCW 48.41.070 and procedures promulgated by the National Association of Insurance Commissioners and the Office of the Insurance Commissioner (OIC), an examination of the financial and market conduct affairs has been performed of:

Washington State Health Insurance Pool
P. O. Box 269
Bow, WA 98232-0269

In this report, Washington State Health Insurance Pool is referred to as "WSHIP" or the "Pool."

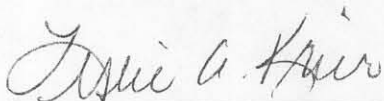
This report of examination is respectfully submitted.

CHIEF EXAMINER'S REPORT CERTIFICATION and ACKNOWLEDGEMENTS

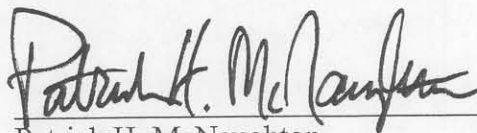
This examination was conducted in accordance with Office of Insurance Commissioner and National Association of Insurance Commissioners procedures for financial and market conduct examinations. Nancy L. Barnes, AIE, ACS and John R. Jacobson, AFE of the Washington State Office of Insurance Commissioner performed this examination and participated in the preparation of this report.

The examiners wish to express appreciation for the courtesy and cooperation extended to them by WSHIP as well as by the personnel of Outsourced Administrative Systems, Inc. during the course of this examination.

We certify that the following is the report of the examination, that we have reviewed this report in conjunction with pertinent examination work papers, that this report meets the provisions for such reports prescribed by the Office of Insurance Commissioner, and that this report is true and correct to the best of our knowledge and belief.



Leslie A. Krier, AIE, FLMI
Chief Market Conduct Examiner
Office of the Insurance Commissioner
State of Washington



Patrick H. McNaughton
Chief Examiner
Office of the Insurance Commissioner
State of Washington

FOREWORD

This examination was completed in two sections. The market conduct section was completed by applying tests to each examination standard. Each test applied during the examination is stated in this report and the results are reported. Exceptions are noted as part of the comments for the applied test. The financial examination section was completed by exception. The focus of the financial examination was on the effectiveness of internal controls procedures and did not include a review of the financial statements filed by WSHIP. Only those areas found to contain violations of Washington law and regulations are included in this report.

Throughout the report, where cited, RCW refers to the Revised Code of Washington, and WAC refers to Washington Administrative Code.

Scope

Time Frame

This was the first market conduct examination and first financial examination of the Washington State Health Insurance Pool (WSHIP). The examination covered WSHIP's operations from January 1, 2001 through June 30, 2002. In some instances, the review period was extended to cover a more current time frame. These areas will be noted in the report. This examination was performed both in the Seattle OIC office and on-site at Outsourced Administrative Systems' office in Indianapolis, Indiana.

During the time period covered by this examination, Chapter 284-91 WAC, was in effect and as such, we have based our examination standards on this Chapter. Subsequent to the examination period, Chapter 284-91 WAC was repealed when WSHIP's new plan of operation became effective on April 6, 2003.

Matters Examined

The examination included a review of the following areas:

Plan Operations & Management
Advertising
Underwriting
Claims
Financial

Administrative Contracts
Complaints
Rate and Form Filings
Customer Service
Maintenance of Data Records

Sampling Standards

Methodology

In general, the sample for each test utilized in this examination falls within the following guidelines:

92 %	Confidence Level
+/- 5 %	Mathematical Tolerance.

Regulatory Standards

Market conduct samples are tested for compliance with standards established by the OIC. The tests applied to sampled data will result in an error ratio, which determines whether or not a standard is met. If the error ratio found in the sample is, generally, less than 5%, the standard will be considered as "met." The standard in the area of agent licensing and appointment will not be met if any violation is identified. The standard in the area of filed rates and forms will not be met if any violation is identified. This will also apply when all records are examined, in lieu of a sample.

For those standards, which look for the existence of written procedures, or a process to be in place, the standard will be met based on the examiner's analysis of those procedures or processes. The analysis will include a determination of whether or not the company follows established procedures.

Standards will be reported as Passed (without Comment), Passed with Comment or Failed. The definition of each category follows:

Passed	There were not findings for the standard.
Passed with Comment	The records reviewed fell within the tolerance level for that standard.
Failed	The records reviewed fell outside of the tolerance level established for the standard.

Note: The examination standards apply only to the market conduct section of this report.

PLAN OPERATIONS AND MANAGEMENT

Pool History

The Washington State Health Insurance Pool (WSHIP) is a nonprofit entity that was created by the Washington State Legislature in 1987. The purpose of the plan is to provide Washington residents who are denied health coverage by admitted carriers access to health insurance. WSHIP coverage is also available to residents of Washington State counties where commercial, individual medical insurance or commercial Medicare supplemental insurance is not available to the general public.

Any commercial insurer providing disability or stop loss insurance, any health care service contractor, and any health maintenance organization that accepts or denies health coverage to individual applicants participates in the operations of WSHIP. The Washington State Health Care Authority is also included as provider of the state uniform medical plan. The participating carriers fund the operation of WSHIP through financial assessments that are based on each carrier's proportion of participation in the Pool. The proportion of participation is determined annually by the Board of Directors based on annual statements and other reports deemed necessary by the Board and filed by the carrier with the OIC. The requirements for assessments are outlined in RCW 48.41.090 and in the Pool's Plan of Operation.

Pool Management & Operations

WSHIP operations are governed by its Board of Directors. The Board is comprised of ten (10) members. Six (6) of the members are appointed by the Governor. The remaining four (4) members are elected by the companies that participate in the Pool. In addition, the Insurance Commissioner is a nonvoting, ex-officio member. Board members serve three (3) year terms.

As of November 14, 2002, the Board members were:

Board Member Position/Representation	Community Affiliation	Appointed By	Original Appointment Date	Term Expires
Michael Arnis Ex-Officio/Nonvoting	OIC	N/A	9/5/02	N/A
Peter McGough, MD #1/Providers	UW Physicians	Governor	8/2/02	5/31/04
Beth Pitt #2/Carriers (HCSC)	Premiera Blue Cross of WA & AK	Board	1/3/02	5/31/03
Patti L. Carter #3/Small Business	Pony Mailing & Business Center	Governor	5/4/00	5/31/05
Sean Corry	Sprague, Israel, Giles	Governor	5/8/00	5/31/03

Board Member Position/Representation	Community Affiliation	Appointed By	Original Appointment Date	Term Expires
#4/Consumers				
Robert Crittenden, MD #5/Consumers	University of Washington	Governor	5/8/00	5/31/04
Bernie Dochnahl #6/Large Business	N/A	Governor	5/10/00	5/31/03
David Toomey #7/Carriers (Disability)	Aetna Health of WA, Inc.	Board	3/14/03	5/31/05
Patricia Maddock, RHU #8/Agents	Maddock & Associates	Governor	5/8/00	5/31/05
Bob Moore #9/Carriers (HMO)	Group Health Cooperative	Board	2/1/98	5/31/04
Robert S. Kuecker #10/Carriers (HCSC)	Regence Blue Shield	Board	9/5/02	5/31/03

WSHIP is charged with performing its operations in accordance with Chapter 48.41 RCW, Chapter 284-91 WAC, and a Plan of Operation. The Plan of Operation is filed with the Office of Insurance Commissioner. The original plan was approved by the Board of Directors on January 8, 1988, and filed with the OIC on March 23, 1988. An amendment to the Plan of Operation was filed September 13, 1999 to bring it into compliance with rules regarding eligibility and to clarify the Board's policies regarding assessment appeals. The original Plan of Operation consisted of a single document encompassing the organizational functions and operational purpose of the Pool. This plan did not include Bylaws.

Subsequent Event: On September 5, 2002, the Board of Directors approved an amended Plan of Operation which was submitted to the OIC on September 6, 2002. The Plan was effective April 6, 2003. This Plan consists of three documents: Articles of Organization, Bylaws, and Operating Rules.

The Plan of Operation states the purpose of the Pool. In addition, it outlines the general powers and authority of the Board which is to offer specific types of health coverage to high risk individuals unable to obtain coverage through other means.

The Plan of Operation directs the Board to:

- Establish procedures for handling and accounting of assets and monies of the Pool
- Establish regular times and places for meetings
- Establish procedures for records of all financial transactions and for an annual fiscal reporting to the OIC
- Provide for the execution of the powers and duties of the Pool

- Establish procedures for the collection of assessments from the carriers
- Establish the amount of assessment
- Select an administrator to conduct the day-to-day operations of the Pool.

In order to oversee operation of the Pool, the Board hired Kären Larson as WSHIP's Executive Director on May 24, 2001. Ms. Larson is the second Executive Director since inception of the Pool. The Executive Director supervises and controls the administrative business and affairs of the Pool. The Executive Director has one assistant. WSHIP pays a fee to the plan administrator for the services of a privacy officer. The privacy officer is responsible for implementing compliance with HIPAA Privacy Regulations that go into effect April 2003. These are the only employees of the Pool.

The Plan of Operations calls for the Board of Directors to select an administrator to conduct the day-to-day operations of the Pool. The administrator is selected through a competitive bidding process as outlined in RCW 48.41.080.

The examiners reviewed the board meeting minutes from the examination period. The annual meeting is held in March of each year. At that time, Board members that are not appointed by the Governor are elected for the term to begin on June 1st. Regular board meetings are held every two (2) months to discuss WSHIP operations and administrator performance. Regular meetings are open to the public and are well represented by health carriers and consumer assistance and advocacy groups. Public comments are invited at the regular meetings. Special meetings are held as necessary.

Findings

The following Plan Operations & Management Standards passed without comment:

#	Plan Operations & Management Standard	Reference
3	The plan of operation contains all required provisions.	RCW 48.41.050
4	The board selects an administrator to administer the Pool through a competitive bidding process. The administrator performs duties as assigned by the board.	RCW 48.41.080

The following Plan Operations & Management Standard passed with comment:

#	Plan Operations & Management Standard	Reference
1	The Board of Directors is selected as required by statute.	RCW 48.41.040(2)

Plan Operations & Management Standard #1:

RCW 48.41.040(2) states that the Board must elect four (4) members from the pool. "...The elected members shall, to the extent possible, include at least one representative of health care service contractors, one representative of health maintenance organizations, and one representative of commercial insurers which provides disability insurance." The current elected members consist of three HCSC members and one HMO member. One of the HCSC

members works for a company that has an affiliate company which writes disability insurance in Washington state. The Board considers this person to be representative of the commercial insurance market. The Board has made attempts to find a commercial disability company member but has been unsuccessful to date.

The following Plan Operations & Management Standards failed:

#	Plan Operations & Management Standard	Reference
2	The board shall submit to the commissioner a plan of operation for the Pool and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Pool.	RCW 48.41.040(4)

Plan Operations & Management Standard #2

The Board recognized that the 1999 amended plan of operation was no longer in compliance. Changes to WSHIP operations from 1999 until 2002 were not submitted to the OIC as an amendment to the Plan of Operation. The existing plan did not include Bylaws and a number of statutory changes to Chapter 48.41 RCW occurred in 2000 and 2001. To rectify this, the Board submitted an amended Plan of Operation to the OIC on September 6, 2002. This plan was subsequently approved by the OIC, to be effective April 6, 2003.

GENERAL EXAMINATION STANDARDS

The examiners reviewed the compliance of the Administrator with the requirements of the Administrative Service Agreement. They also reviewed the processes in place for the Board to oversee the Administrative Service Agreement provisions.

It appears from this review that, during the examination period, the Board received reports from the Administrator concerning performance as required by the Administrative Service Agreement between OASYS and WSHIP. Monthly performance was reported to the Board, but the Board did not appear to require back up documents, nor did it follow up on issues that were out of compliance with the Agreement. This practice reflects the Board's failure of its fiduciary duty by accepting the results without any type of audit to verify the numbers being reported. As of July 1, 2002 the Plan of Operation required the Board to obtain a written corrective action plan from the Administrator when performance standards are not met for two consecutive months. The examiners found that the Administrator did not meet the performance standards in July, August and September 2002. When the examiners requested a copy of the corrective action plan, the Board advised that a plan had not been completed. The examiners findings in this area are included where appropriate throughout the report.

The following General Examination Standards passed without comment:

#	General Examination Standard	Reference
1	The Company and its representatives do business in good	RCW 48.01.030

#	General Examination Standard	Reference
	faith, and practice honesty and equity in all transactions.	

The following General Examination Standard passed with comment:

#	General Examination Standard	Reference
3	The Company may not discourage members from contacting the OIC and may not discriminate against those members that do contact the OIC.	WAC 284-30-572(2)

General Examination Standard #3:

Comments regarding this standard appear under the Contract and Member Handbook section and the Complaint section of this report.

The following General Examination Standard failed:

#	General Examination Standard	Reference
2	Every person being examined, including its officers, employees, and representatives, must facilitate the examination process by providing its accounts, records, documents, and files to the examiners upon request.	RCW 48.03.030(1)

General Examination Standard #2:

While the Executive Director was cooperative with examiners, this attitude did not extend to the Administrator. There were instances in which the examiners found it difficult to work with the Administrator. For example, the Administrator would not release claim file information to the examiners because the OIC would not sign a confidentiality agreement. The Administrator felt that in order for it to comply with HIPAA regulations, a signed confidentiality agreement was necessary. It was necessary for the Executive Director to intervene before the examiners were allowed to review records.

Subsequent Event: On August 7, 2003, the exam team was informed by copy of an email from the Executive Director of WSHIP that the system data reviewed by the examiners was not the data that resides on the OASYS system but a separate data base created for the examiners that was limited to WSHIP data only. In an email, the Executive Director stated that "Ann reminded me that the auditors had refused to sign a confidentiality statement which OASYS believes to be required by HIPAA, and as a result, the auditors did not have full access to the OASYS claim processing system." The examiners informed OASYS that as a Health Oversight Agency as defined in HIPAA regulation §164.501, the agency is allowed to disclose information to the OIC without special permissions as prescribed in HIPAA regulation §164.512(d)(1) Standard: uses and disclosures for health oversight activities. This section states "A covered entity may disclose protected health information to a health oversight

agency for oversight activities authorized by law, including audits;.....". OASYS agreed that the examiners would be allowed access to information without signing a confidentiality statement. OASYS or the Executive Director did not inform the examination team that they would be denied access to their system, nor did they disclose this information to the team at any time during the examination process. While performing the examination, the team was under the impression that they were working with the actual system, not a point in time data base created for them. Because of the information obtained in the email, the examiners are not certain that the data reviewed during the examination process was either complete or accurate.

RCW 48.41.070 provides that the Pool is subject to chapter 48.03 RCW. By taking the above action, WSHIP is in violation of RCW 48.03.030(1) which states: "Every person being examined, its officers, employees, and representatives shall produce and make freely accessible to the commissioner the accounts, records, documents, and files in his possession or control relating to the subject of the examination and shall otherwise facilitate the examination."

MARKET CONDUCT EXAMINATION

ADVERTISING

Requirements for WSHIP eligibility and procedures for enrollment are publicized through the WSHIP webpage, the application packet, and information obtained from health carriers who have rejected an application for individual coverage. WSHIP also works with enrollee advocates that receive regular updates of materials and board activities and actions.

In December 2000, the WSHIP Board of Directors approved a recommendation for carrier reporting and WSHIP outreach to health screened individuals. In July 2002, the WSHIP Board of Directors approved measures to encourage involvement in the application process by the agent and broker community. The Board voted to raise the agent fee to \$50.00 per each acceptable application to the Pool.

The examiners reviewed the webpage and the application packets that were used during the examination period. The webpage and the application packets meet the advertising requirements set forth in Chapter 48.41 RCW.

Findings

The following Advertising Standard passed without comment:

#	Advertising Standard	Reference
2	The administrator shall prepare a brochure outlining the benefits and exclusions of the Pool policy in plain language and make the brochure available to participants and potential participants.	RCW 48.41.110(2)

The following Advertising Standard failed:

#	Advertising Standard	Reference
1	The plan shall develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment, and maintain public awareness of the plan.	RCW 48.41.050(8)

Advertising Standard #1:

The Plan of Operation states that the plan administrator will develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment, and to maintain public awareness of the plan. Section 1.9 of the Plan of Operation charges OASYS, the plan administrator, with implementation of the program and maintaining public awareness. One of the facets of the advertising plan is carrier notification to WSHIP of rejected applications. Carriers are required to report monthly to WSHIP the rejected applicant names and addresses. The plan calls for WSHIP to verify the number of rejected applicants and

conduct followup communications with these persons. In an interview with OASYS's Account Executive and Enrollment Specialist on January 13, 2003, the examiners were informed that this process is flawed. Both commented on problems experienced with notification of rejection from the carriers. The Account Executive elaborated by commenting that WSHIP's website has a secure location designed for carrier access. The carriers are instructed to download the rejection information. The Account Executive stated that she believed that the information was either not being downloaded, and if it was, it was being downloaded incorrectly. OASYS made attempts to cross-reference this information with the applications that it received. Due to system problems, the data that was downloaded was unreliable. System enhancements were implemented to enable more credible data to be received by OASYS. However, at the time of the interview, the Account Executive stated that followup was not being conducted, primarily due to a lack of resources.

COMPLAINTS

Procedures

The examiners were provided with copies of the appeals and grievance procedures in use during the examination period.

The procedures offer a WSHIP applicant or participant three (3) levels of appeals. The first two (2) levels are internal. The first complaint goes to WSHIP's administrator (OASYS). The second level is the WSHIP grievance committee. The third level of appeal is external and may be made to a designated independent review organization (IRO). The procedures detail steps that applicants and participants need to take if they believe that errors have occurred either in the scoring and administration of the Standard Health Questionnaire (SHQ) or an action or decision made by WSHIP. The procedures provide a timeline showing when communications may be expected during the course of the appeal or grievance.

Verbal inquiries are taken by the Customer Service Representatives and routed to the Appeals Specialist for handling. Written appeals are received in the mailroom, opened, sorted and scanned. The scanned documents are reviewed by an input clerk and placed into queues to be handled by the Appeals Specialist. At the time of the examination, one employee was dedicated to handling complaints, appeals and grievances for WSHIP. The WSHIP Account Executive was assisting with the process because of the large volume of complaints.

The procedures in effect during the examination period call for all complaints, appeals and grievances to be responded to within 30 business days.

Subsequent Event: Effective September 5, 2002, the procedures were amended to reflect that OASYS will respond to a complaint within 30 calendar days.

Complaint File Review

OASYS provided the examiners with a log of 132 complaints, appeals and grievances received during the examination period. The examiners selected a random sample of 50 files for review. Two of the requested files were not available to the examiners. The files were complaints from applicants who were denied coverage from the Pool. Records for these complaints are held for a short period of time and then destroyed with the application file. There were 48 complaints reviewed.

Current procedure calls for complaints to be scanned and sent to the appropriate party for handling within 24 hours. It appears that this was not the case during the exam period. The examiners found that 4.3 days was the average time from receipt in the mailroom to scanning, then additional time was required to get the complaint to the appropriate party.

The average response time to a participant with a complaint is 46.8 business (67.1 calendar) days. The OASYS procedures in effect during the examination period call for a response within 30 business days. OASYS personnel indicate that the primary reasons for delay in response are staffing issues and complaint documents scanned to incorrect processing queues. The following chart shows the reasons and dispositions of the 48 files reviewed:

Reason	Number	Overturned	Upheld	No Decision
Benefits	7	4	3	
Claim Handling	10	7	3	
Effective Date	6	4	1	1
Eligibility	6	5	1	
Preexisting Conditions	4	1	2	1
Premium Collection/Billing	13	10	2	1
Rates	2			2
Total	48	31	12	5

Thirty-one (31) files (64.6%) had original decisions overturned on appeal. Claim adjudication, underwriting, and billing are significant areas of concern.

Claim Adjudication:

The examiners concluded that OASYS's claims processing system does not cross-reference to a participant's benefit plan maximums. Two (2) of the complaints involved claims for which benefits continued to be paid well after the maximum visit limit or maximum dollar limits had been reached. When WSHIP noted the error, benefit payments ceased without any notice to providers or participants. Upon appeal, WSHIP agreed to pay claims through the date of appeal as an exception.

Data entry and processing errors attributed to seven (7) of 10 complaints that were overturned:

- A precertification penalty was assessed to one (1) claim in error.

- One (1) claim was denied as a duplicate and should not have been. The claim was for hospital services for delivery of a baby. The first submission was denied as it required additional information for processing. Subsequent submissions were then denied as duplicates. It took 11 months from the date of delivery to the date of claim payment.
- The incorrect number of units/visits was entered into the computer system on one (1) claim. It took OASYS over five (5) months to investigate this member's appeal and make corrections to the claim.
- Four (4) claims involved untimely claims payments.

Application Process:

Due to delays and errors in the application process, four (4) applicants requested later effective dates than the effective dates noted on the application. If a requested effective date is not provided, the application states that coverage will become effective the first of the month following approval. On one (1) application, OASYS ignored the applicant's requested effective date and changed it to reflect the date following termination of prior coverage. Notification of approval on three (3) applications was given to the applicant over 30 days after approval. Due to the delay in notification and the applicant not being aware that coverage was in effect, appeals were entered to change the effective dates of coverage.

Premium Billing:

Ten (10) of 13 overturned appeals were due to billing errors. These errors are discussed in the Policy Administration section of this report.

OIC Complaints

As stated above, OASYS provided the examiners with a log of 132 complaints received during the examination period. OASYS's records show that 45 of the 132 complaints had OIC involvement. OIC records indicate that 103 complaints concerning WSHIP were received. The discrepancy is attributed to a lack of proper tracking of complaints, appeals and grievances. When asked to provide a log of complaints received from the OIC, OASYS responded that this information is not tracked.

Sixteen (16) of the 48 files selected in the random sample had OIC involvement and were tested for timely and substantial response to the OIC within the 15 business day requirement set forth in WAC 284-30-360(2), WAC 284-30-650, and Technical Advisory T 98-4. Even though WSHIP was not subject to this requirement during the examination period, the examiners reviewed the OIC complaints to determine the length of time from receipt by OASYS to response to the OIC. The average response time to the OIC was 14.6 days. However, in five (5) of the 16 files reviewed, OASYS failed to respond to the OIC within 15 business days of receipt of the complaint.

Subsequent Event: OASYS began maintaining separate logs of complaints received from the OIC on February 11, 2003. OASYS provided logs from February 11, 2003 through August 31,

2003. Records provided by OASYS reconcile to OIC records for that same time period. OASYS also implemented procedures to audit WSHIP OIC grievances and complaints effective March 1, 2003. One hundred percent (100%) of all OIC-generated grievances and complaints are subject to audit. Each file is audited to assure compliance with contractual and regulatory guidelines, including 15 business day timeliness requirements.

The following chart shows the reasons and dispositions of the 16 files reviewed:

Reason	Number	Overtured	Upheld	No Decision
Benefits	1	1		
Claim Handling	5	3	2	
Effective Date	0			
Eligibility	3	2	1	
Preexisting Conditions	2		2	
Premium Collection/Billing	4	3	1	
Rates	1			1
Total	16	9	6	1

Subsequent Event: Under the new plan of operation which was effective April 6, 2003, WSHIP is subject to the requirements of WAC 284-43-650. WAC 284-43-650 and Technical Advisory T 98-4 require response to the OIC within 15 business days of receipt of a complaint. The response must include the substantial information requested by the OIC.

Findings

The following Complaint Standard passed without comment:

#	Complaint Standard	Reference
1	The plan of operations establishes procedures under which applicants and participants may have grievances reviewed by an impartial body and reported to the board.	RCW 48.41.050(9)

The following General Examination Standard passed with comment:

#	General Examination Standard	Reference
3	Members may not be discouraged from contacting the OIC and discrimination against those members that do contact the OIC is prohibited.	WAC 284-30-572(2)

General Examination Standard #3:

The grievance procedures state the following:

“... The reviewed decision can be appealed to the Grievance Committee of the Washington State Health Insurance Pool. The decision of the Grievance Committee will be reported to the full Board of Directors. If the Board fails to act within 60 days or if you wish to appeal the action of the Board, you may then appeal to the Insurance Commissioner.”

This statement implies that the OIC may only be contacted after all avenues of the appeals and grievance process has been exhausted.

Subsequent Event: The examiners reviewed WSHIP's most recent policy form filing. The filing was received September 17, 2002, approved December 5, 2002, and placed into effect January 1, 2003. The language referenced above has been removed from the policy. The description of the appeals and grievance procedures has been written to comply with WAC 284-30-572(2).

RATE AND FORM FILING

The WSHIP board is charged with developing rates for the plans offered by the Pool. The examiners reviewed the rating tables in use during the examination period and found the rates match those filed with the OIC. WSHIP is not required to file its rates with the OIC. However, it historically files the rates with the OIC for informational purposes only. The OIC confirms that the rates being charged are in compliance with RCW 48.41.200(1). It requires that WSHIP determine the standard rate charged for coverage comparable to pool coverage by the five (5) largest carriers offering individual coverage in the state. The OIC verifies that the rates charged do not exceed the maximum allowed by statute.

WSHIP is required to file its policy forms and obtain OIC approval prior to use. The examiners reviewed the filings and found that they had been properly filed with the OIC and approval obtained prior to being sold. WSHIP offers three plans – a standard plan, a network plan, and Medicare plan. All three (3) plans were filed November 15, 2000, approved November 16, 2000, and were in use from January 1, 2001 through January 1, 2003. Policy forms effective January 1, 2003 were filed September 17, 2002 and approved December 5, 2002.

Findings

The following Rate and Form Filing Standards passed without comment:

#	Rate and Form Filing Standard	Reference
1	The board shall establish appropriate rates, utilizing appropriate risk factors in accordance with established actuarial underwriting practices as listed in RCW 48.44.022 and RCW 48.46.064.	RCW 48.41.060(1)(d)
2	All policy forms issued by the Pool shall be filed with and approved by the commissioner before they are used.	RCW 48.41.130
3	Rates may not change except on a class basis. The Pool's right to change rates must be clearly disclosed in the policy.	RCW 48.41.160(2)

CONTRACTS AND MEMBER HANDBOOKS

The examiners reviewed the application forms and policies that were in use during the examination period. All of the forms and policies that were filed had been reviewed and approved by the OIC. Comments regarding the filings are noted in the Rate and Form Filing section of this report.

Findings

The following Contract and Member Handbooks Standards passed without comment:

#	Contract and Member Handbooks Standard	Reference
1	The Pool shall offer one or more care management plans of coverage.	RCW 48.41.110(1)
2	Plan benefits shall include the described minimum coverage.	RCW 48.41.110(3)
3	The board shall design and employ cost containment measures.	RCW 48.41.110(4)
4	The Pool benefit policy may contain benefit limitations, exceptions, and cost shares consistent with managed care products. No limitation, exception or reduction may be used to exclude coverage for any disease, illness, or injury.	RCW 48.41.110(5)
5	The contracts shall contain the deductible, coinsurance, out-of-pocket payment, and carryover requirements as defined.	RCW 48.41.120
6	Coverage for adopted and newborn children shall include care and treatment of medically diagnosed congenital defects and birth abnormalities.	RCW 48.41.140(1)

#	Contract and Member Handbooks Standard	Reference
7	The board shall offer a medical supplement policy for persons receiving Medicare Parts A and B.	RCW 48.41.150

The following General Examination Standard passed with comment:

#	General Examination Standard	Reference
3	Members may not be discouraged from contacting the OIC and discrimination against those members that do contact the OIC is prohibited.	WAC 284-30-572(2)

General Examination Standard #3:

Policy forms in effect during the examination period contained the following language concerning the appeal and grievance process:

“... The reviewed decision can be appealed to the Grievance Committee of the Washington State Health Insurance Pool. The decision of the Grievance Committee will be reported to the full Board of Directors. If the Board fails to act within 60 days or if you wish to appeal the action of the Board, you may then appeal to the Insurance Commissioner.”

This statement implies that the OIC may only be contacted after all avenues of the appeals and grievance process have been exhausted.

Subsequent Event: The examiners reviewed WSHIP's most recent policy form filing. The filing was received September 17, 2002, approved December 5, 2002, and placed into effect January 1, 2003. The language referenced above has been removed from the policy form filings. The description of the appeals and grievance procedures has been written to comply with WAC 284-30-572(2).

UNDERWRITING

Underwriting Process

The examiners met with the OASYS account executive and enrollment specialist to discuss the enrollment and underwriting process.

Applications are received in the mailroom and date stamped. A copy of the application is made and the enrollment specialist works from the application copy. Original applications are maintained on site in a separate file during the application process. If the application is approved, the original application continues to be maintained on site as long as the policy is in-force. If coverage is terminated or if an application is not approved, the original application is pulled and transferred to offsite storage where it is maintained for seven (7) years.

The application data is entered into the computer system 24 to 48 hours after it has been received. The application is reviewed by the specialist to assure that it is complete. If additional information is required, a letter is sent to the applicant listing those items needed. The applicant is provided with a 30-day deadline to return any outstanding information. If the information is not received within 30 days, another letter, stamped "2nd request", is mailed. The second letter gives the applicant an additional 30 days to return the outstanding information and includes a notation that the application will be closed if the information is not received within that timeframe.

When all application information is received, the application is approved. An approval letter, policy, and identification cards for both medical and pharmacy services are prepared and mailed to the participant.

OASYS receives an average of 150 WSHIP applications per month. OASYS personnel state that only 25 percent of the applications are approved on initial submission. Many of the applications require additional information. The administrator believes this is because the application form in use during the examination period contained confusing instructions regarding documentation requirements (i.e., proof of residency, rejections letter, premium, etc.).

Subsequent Event: A new application was effective January 1, 2003. The application includes a checklist that clearly states documentation requirements for participation in WSHIP.

Underwriting File Review

OASYS received 1,813 WSHIP applications during the examination period. The following is a breakdown of the disposition of these applications:

Status	Number	Percentage
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Status	Number	Percentage
Approved for Coverage	1,445	79.7%
Declined for Coverage	334	18.4%
Withdrawn by Applicant*	34	1.9%
Total	1,813	100%

*OASYS began tracking this category in April 2002.

The examiners selected a random sample of 50 underwriting files for review. The underwriting files were reviewed to assure that applicants were treated fairly and to assure that the administrator's policies and procedures were followed.

Of the 50 files reviewed, 40 applications were approved for coverage, four (4) applications were rejected, and six (6) applications were withdrawn. An average of four (4) days passed before applications were initially reviewed, and it took an average of 41 days from receipt of application to approval.

The examiners determined that the reason for long delays in processing applications occurred because the administrator had only one enrollment specialist to process applications. If that person was absent, the work would not get done.

Subsequent Event: OASYS added backup staffing on February 3, 2003.

Findings

The following Underwriting Standards passed without comment:

#	Underwriting Standard	Reference
1	The plan administrator shall administer eligibility functions relating to the Pool.	RCW 48.41.080(3)(a)
2	Any person who provides evidence within 90 days of a carrier's declination based on the standard health questionnaire is eligible for coverage.	RCW 48.41.100(1)(a)
3	Once a person is eligible for coverage under the Pool, that person will remain eligible until they no longer qualify for Pool coverage.	RCW 48.41.100(1)(b)
4	Eligibility for pool coverage is allowed because no carrier or surplus lines insurer offers other than catastrophic coverage in the applicant's county of residence.	RCW 48.41.100(1)(c), WAC 284-91-060(1)
5	A Medicare eligible person is eligible if they are rejected for a Medicare Supplement policy for the reasons listed in the statute.	RCW 48.41.100(1)(d)

#	Underwriting Standard	Reference
6	The Pool may not reject an individual for coverage based upon preexisting conditions but will impose a 6-month waiting period. The preexisting condition waiting period shall not apply to prenatal care.	RCW 48.41.110(6)
7	The Pool shall credit any preexisting condition waiting period for a person who was enrolled at any time during the 63-day period immediately preceding the date of application for the new plan.	RCW 48.41.110(7)(a)
8	If application is made as result of rejection, the date of application to the carrier, rather than to the Pool, should govern for purposes of determining preexisting condition credit.	RCW 48.41.110(8)

POLICY ADMINISTRATION

The contract between WSHIP and OASYS requires OASYS to maintain policy eligibility records as well as establish premium collection procedures.

Policy Administration Standards 2, 3 and 4 were not applicable to this examination because inforce policy records were not reviewed.

The following Policy Administration Standard passed without comment:

#	Policy Administration Standard	Reference
1	The plan administrator shall establish a premium billing procedure for collection of premiums. Billings shall not be more frequent than monthly.	RCW 48.41.080(3)(b)

The following Policy Administration Standard failed:

#	Policy Administration Standard	Reference
5	The plan administrator shall provide timely and comprehensive services for premium billing and collection. These services include rate calculation, enrollee billing, collection of premiums and account reconciliation.	Per Terms of the Administrative Services Agreement

Policy Administration Standard #5:

As discussed in the Complaints section of this report, premium collection and billing practices contributed to 13 complaints, appeals, and grievances. Ten (10) of 13 (76.9%) of these complaints were overturned upon appeal. OASYS personnel informed the examiners that

staffing deficiencies, workflow problems, and internal communication failures were the cause of many of the problems.

The following are examples of the errors:

- WSHIP procedures stated that if members retroactively terminate coverage for any reason, the amount(s) paid out as claim dollars while covered by WSHIP are subtracted from any premium refund. If the claim cost was higher than the premium, WSHIP required payment from the member(s). This practice inappropriately mixed the accounting of premium and claim dollars which distorts the accounting records of the Pool as to both premium and claims. Effective April 21, 2002 this procedure was changed. One (1) complaint was received concerning this practice.
- A participant was working with a patient advocate for assistance with premium payment. The participant's policy had been terminated and she was requesting reinstatement. The patient advocate was notified of the amount to bring the policy current. This amount was paid in January 2001. The reinstatement appeal was not resolved until September 2001. Eight (8) months had now passed and considerable premium was due to bring the policy current.
- An applicant applied for coverage for an effective date of January 2000 and paid one month's premium with application. The application was not approved until two (2) months had passed (March 9, 2000). The applicant selected monthly electronic funds transfer (EFT) as the mode of premium payment, and premium withdrawals began April 2000 (April 2000 premium withdrawal paid February 2000 premium). EFT continued and the participant's policy remained two (2) months in arrears. The first notification that member received regarding premium delinquency was in July 2001 after member had incurred \$12,000 in hospital claims.
- An applicant was approved by the Pool for a March 1, 2001 effective date. The applicant was simultaneously appealing to the rejecting carrier and was subsequently approved for a March 1, 2001 effective date. OASYS erroneously entered the applicant's effective date with them as January 18, 2001 and a partial refund was generated.
- A member requested a change from quarterly to monthly billing. The request was scanned into the computer system, but no action was taken to make the requested change.
- A member received a letter stating that his policy was subject to cancellation if delinquent premiums were not received. The premiums had been paid by a patient advocate group but had never been credited to the member's account.
- A member applied for a \$1,500 deductible policy. The policy was approved; however OASYS began incorrectly drafting a higher premium for a \$500 deductible policy, resulting in the member's bank account being overdrawn. The member requested a temporary halt to the electronic funds transfer until the accumulated premium credit had been exhausted. OASYS continued drafting the incorrect premium amount. The member felt compelled to stop the established electronic funds transfer as she had paid

more premiums than due and OASYS continued drafting premium. The member requested an alternative payment arrangement be implemented after the premium credit had been exhausted. A new electronic funds transfer or quarterly billing was not started. WSHIP terminated this member's policy when the premium credit was used and the member had to apply for reinstatement.

During the underwriting review, the examiners found 25 of the 50 applications reviewed listed additional premium as a requirement. The high volume (50%) is attributed to the confusion on the application regarding the application of premium discounts. Discounts are available to applicants based on income, prior coverage, and length of time enrolled in WSHIP. Many applicants submitted the listed premium for one of the available discounts assuming that they would qualify. If an applicant does not qualify for one of the discounts, additional premium is required to complete processing of the application. The application was revised April 2003. However, it still opens the door for confusion. The application states "If you are applying for the low income discount, you first must pay the amount due for one month's premium in order to activate your coverage." The application does not state that the prospective member must pay the NON-DISCOUNTED premium amount. Unless the full premium is received, the application will be pended for the additional money. The application form continues to show both discounted and non-discounted premium amounts, which infers that the applicant has the choice of amounts to pay depending on their assumption of discount qualification.

Subsequent Event: WSHIP and OASYS contractually agreed to institute billing audits effective January 1, 2003.

ADMINISTRATIVE CONTRACTS

WSHIP contracts with four (4) entities for administrative services. These are:

- Outsourced Administrative Systems Inc. (OASYS)
- First Choice Health Network
- Washington State Health Care Authority
- Provantage Prescription Benefit Management Services Inc. (now SysMed, a subsidiary of Merck-Medco)

Outsourced Administrative Systems Inc. (OASYS):

The examiners were provided with an Administrative Service Agreement executed by Anthem Insurance Companies. This agreement was effective July 1, 1998 through June 30, 2001. The contract called for all operations to be conducted through Anthem's third party administrator, Outsourced Administrative Systems, Inc. (OASYS). OASYS was spun-off as a wholly-owned subsidiary of Anthem on October 1, 1998. The contract executed for the period July 1, 1998 through June 30, 2001 was extended by board approval for the period July 1, 2001 through June 30, 2002.

A new contract was executed between WSHIP and OASYS for the period July 1, 2002 through June 30, 2005. On February 25, 2002, OASYS was purchased by ACS Healthcare Solutions and is now a wholly-owned subsidiary of ACS Healthcare Solutions.

The following services are to be provided:

- Health status questionnaire
- Applications and enrollment
- Premium billing and collection
- Claims processing
- Customer service
- Utilization management
- Grievances and appeals
- Reasonable interface and collaboration with other contracted entities
- Advertising and marketing
- Administration of OIC rate filings
- Printing and distribution of all forms and materials related to WSHIP

OASYS is also responsible for member assessments and banking and financial functions. These items are discussed in the financial examination section of this report.

The contract between WSHIP and OASYS contains performance standards for processing accuracy and timeliness. OASYS reports its performance to the Board at each board meeting. OASYS claims to consistently meet or exceed performance standards. However, the examiners could not rely on the integrity of the data used to measure performance and were unable to confirm the figures reported to the Board of Directors. The examiners found that OASYS does not maintain adequate staff to administer the day-to-day operations of WSHIP. Any delays in enrollment processing, claims processing, and addressing grievances and appeals were attributed to inadequate staffing and workflow issues. Additional comments regarding the system capabilities and data integrity are discussed in the financial examination section of this report.

First Choice Health Network:

WSHIP contracted with First Choice Health Network (FCHN) November 1, 1999 to provide its network to WSHIP participants enrolled in its preferred provider plan. FCHN is responsible for repricing provider claims to reflect the negotiated rate between FCHN and the contracted provider.

Payment to FCHN is based on a percentage of network savings. The payment is billed and paid monthly. The contract between WSHIP and FCHN includes a provision allowing WSHIP to audit the books, records, and financial statements of FCHN that are in relation to this agreement. The only oversight conducted by WSHIP consists of the WSHIP Executive Director's review and approval of the monthly billing statements.

Washington State Health Care Authority:

WSHIP contracts with the Washington State Health Care Authority (HCA) as required by RCW 48.41.060(1)(h) for the administration of premium discounts. HCA's role is to conduct income eligibility reviews of individuals who apply for the premium discount. If an applicant qualifies for a premium discount based on federal income guidelines, the applicant's premium is subsidized by HCA. The subsidy amount paid by HCA is forwarded to WSHIP as a lump sum payment on a quarterly basis. HCA receives specific appropriation for performing this service through legislative funding. There is no monetary compensation between WSHIP and HCA for these services.

The Executive Director meets with HCA on a quarterly basis to review HCA's records.

Provantage Prescription Benefit Management Services Inc.:

WSHIP has contracted with Provantage Prescription Benefit Management Services Inc. for the following services:

- Prescription claims processing
- Formulary management services
- Prescription drug mail services

This contract was effective January 1, 1999 and renews annually.

Provantage bills WSHIP semi-monthly. The Plan has delegated review and approval of the semi-monthly billings to OASYS. Oversight consists of the WSHIP Executive Director's receipt and review of the monthly utilization reports.

CLAIMS

Claim Processing Manual

OASYS provided the examiners with the claims manual used to adjudicate WSHIP claims. The manual provided a description of workflow in the claims department. The examiners found the manual to accurately describe the processes in place.

Claims Processing

Electronic and paper claims for WSHIP's traditional plan and Medicare plans are sent directly to OASYS. First Choice Health Network forwards reprinted claims for WSHIP's preferred provider plan to OASYS. The average number of professional and hospital claims for WSHIP

received daily is 263. Any pharmacy claims received at OASYS are forwarded to Provantage. Electronic claims are submitted to a clearinghouse system which in turn formats the claims and transmits them to the computer system. Mailroom personnel examine all incoming paper claim forms for completeness. If the claim form is incomplete, the form is returned to the sender with correspondence showing the reason for returning the claim. Complete claims are sorted and batched by type. The batches are scanned into the computer system. The scanner automatically codes each document with a document number. The total number of claims per batch cover sheet is compared to the total number of claims imaged. If the totals do not match, the batch is re-run. A daily reconciliation of the claims inventory spreadsheet to the batch status report is performed to ensure all incoming claims were imaged. Hard copies of the claims are maintained onsite for 90 days. After 90 days, these documents are shredded.

The images of the claims that have been batched and scanned are downloaded to queues. Input clerks access the oldest queue first to begin claim processing. Each claim is reviewed to confirm that the claimant and provider were entered into the system correctly. The system automatically validates procedure codes, diagnostic codes, and provider type. The system also validates that total charges equal the sum of all detail lines entered. The system is also capable of flagging potential duplicate claims and prevents duplicate claims from being processed. The input clerk can reject a claim within the system if it is missing information. A rejected report is run daily and appropriate actions are determined. There are currently two (2) fulltime input clerks that handle Washington, Colorado and Iowa.

After the input clerks have completed their work, the claim batches are submitted to the claims processors. There are two (2) fulltime processors dedicated to processing only claims for WSHIP. The processors perform manual claims adjudication. The processors are responsible for verifying payment calculations, deductibles, coinsurance, visit or dollar amount benefit limits, and out-of-pocket maximums. After this data is confirmed, the claim is released for payment.

Only 17% of WSHIP claims are auto-adjudicated. The Administrative Services Agreement between WSHIP and OASYS, effective July 1, 2002, defines a "clean claim" as one that requires no additional information or documentation prior to adjudication. The OASYS claims procedure manual workflow indicates that a "clean" claim will pass through the claim processing system. The claim processing system is programmed with edits to prevent claims that require additional information or high dollar claims from auto-adjudication.

Any claims over \$10,000 require supervisor approval. The supervisor is allowed to release claims up to \$20,000. Claims between \$20,000 and \$25,000 may be released by the supervisor after nursing review. All other claims over \$25,000 must be approved by the claims manager.

To assure proper payment and auditing of high dollar claims, any claims equal to or greater than \$10,000 may not be released by a claims processor. Depending on the total amount of the

claim, approval from a supervisor, manager, senior quality assurance auditor, or director must be obtained prior to release for payment.

During the examination period, claim payment checks were printed on Tuesdays and Thursdays. Subsequent to the examination period, check printing is now conducted on Mondays, Wednesdays, and Fridays. OASYS standards call for all checks to be mailed within 36 hours of check printing.

Internal Claims Auditing

The examiners were provided with copies of internal claims audits performed during the examination period. OASYS conducts internal audits of paid and denied claims for all accounts on a post-payment basis. Internal claims audit standards are monitored by the compliance department and account results are communicated to management on a monthly basis. Unacceptable error rates are referred to the quality management team for corrective action. Claims audits are performed weekly by a senior quality assurance auditor and conducted on a random sample basis. The percentage of production subject to audit can vary based on claims processor experience, claim amount, and contract requirements.

OASYS produces monthly audit reports. The results of these reports are used to determine workflow, staffing issues, and compliance with contractual performance standards. The following table is a summary of the internal audits performed by OASYS between January 2001 and June 2002:

Claims Processed	Claims Audited	Claims with Errors	Percentage
83,968	4,481	1,114	24.9%

The errors discovered are split into two categories – clerical errors and financial errors. Clerical errors are all data entry errors that do not involve the actual payment of the claim. The data fields that are reviewed include claim number, claim receipt date, patient name, member identification number, provider name, payee, diagnosis code, dates of service, explanation of benefits codes, and coordination of benefits codes. Financial errors include any data entry errors related to the amount of the claim or amount of payment on the claim. Internal standards are 95% for clerical accuracy and 98% for financial accuracy.

The following is a summary of the clerical error findings:

# of Data Fields Reviewed	# of Clerical Errors	Percentage of Clerical Errors
122,851	1,168	1.0%

The following is a summary of the financial errors:

# of Financial Errors	Total Amount of Claims Audited	Errors by System or Processor	# of Errors	Total Amount of Errors	Percentage of Financial Error
506	\$6,304,373.10	System	51	\$50,332.15	0.8%
		Processor	455	\$240,139.94	3.8%
		Total	506	\$290,472.09	4.6%

Claims Review

OASYS processed 48,801 WSHIP claims during the examination period. The examiners reviewed 142 claims that were randomly selected from the population. An additional 30 claims were randomly selected from the claims received in September 2002. These claims were tested for the standards listed below as well as compliance with stated performance standards in the contract between WSHIP and OASYS.

Findings

The examiners noted clerical and financial processing errors on six (6) of the 172 claims reviewed (3.5%).

The following is a summary of the clerical error findings:

# of Data Fields Reviewed	# of Clerical Errors	Percentage of Clerical Errors
3,268	3	0.1%

The following are the clerical errors that the examiners found:

- The explanations of benefits (EOB) codes on two (2) claims were incorrect. The explanation of benefits used by the processor on one (1) claim stated that Medicare did not cover the service. The correct explanation should have been that Medicare paid the service in full. The processor used an explanation of benefits on one (1) claim that stated that the service was not eligible for payment. The correct explanation should have been that the service was subject to the pre-existing condition waiting period that was still in effect. Upon notification of this error by the examiners, OASYS issued corrected EOBs to the members.
- One (1) claim was processed under the wrong family member. The provider billed with an incorrect member identification number and the input clerk did not recognize the error. The examiners informed OASYS of this error. The claim was reversed and reprocessed under the correct family member's identification number.

The following is a summary of the financial errors:

# of Financial Errors	Total Amount of Claims Audited	Errors by System or Processor	# of Errors	Total Amount of Errors	Percentage of Financial Error
3	\$555,214.50	System	1	\$362.00	< 0.1%
		Processor	2	\$89.73	< 0.1%
		Total	3	\$451.74	0.1%

The following are the financial errors that the examiners found:

- One (1) claim auto-adjudicated only paying four (4) of the five (5) line items on the claim. An adjustment was made to the claim 11 months later to pay the 5th line item.
- One (1) claim had a repricing sheet attached, but the repricing was not entered into the system. Upon notification of this error, OASYS adjusted the claim to reflect repricing.
- One (1) claim contained two (2) line items that were not entered. This same claim also contained two (2) lines items for unrelated procedures that were combined in error. OASYS adjusted this claim to include the line items that were not paid and corrected payment for those items that were combined in error.

The following Claims Standards passed without comment:

#	Claims Standard	Reference
1	The plan administrator shall administer claim payment functions relating to the Pool.	RCW 48.41.080(3)(a)
3	The Pool will be the last payor of benefits whenever any other benefit is available.	RCW 48.41.210
4	The plan administrator shall maintain clerical accuracy of claims processed at a percentage of 95% or greater.	Per the Terms of Administrative Services Agreement
5	The plan administrator shall maintain financial accuracy of claims processed at a percentage of 98% or greater.	Per the Terms of Administrative Services Agreement

The following Claims Standard failed:

#	Claims Standard	Reference
2	The plan administrator shall perform the described necessary functions to assure timely payment of benefits to covered persons under the Pool.	RCW 48.41.080(3)(c)

Claims Standard #2:

The examiners found that 48 of the 172 claim files reviewed (27.9%) were not processed within 30 calendar days. Twenty-six (26) of these files were not processed within 60 calendar days (15.1%). In 2001, the average time from receipt to payment/denial was 57 days.

Improvement is noted in 2002 as the average time decreased to 26.8 days. The average time from receipt to payment/denial for all claims reviewed was 39.7 days.

Performance standards in the OASYS contract that became effective July 1, 2002 call for the following:

- Ninety percent (90%) or more of all clean claims are processed within 15 calendar days of receipt.
- Ninety-eight percent (98%) or more of all clean claims are processed within 30 calendar days of receipt.

As discussed earlier in this section, the examiners selected a sample of 30 claims from September 2002 to test the performance standards. Based on the sample reviewed, the examiners found that OASYS did not meet the processing standards. They found:

- Twenty-six (26) claims were processed in 15 calendar days (86.7%).
- Twenty-seven (27) claims were processed in 30 calendar days (90%).

See Appendix 1.

The contract states that for any month OASYS fails to meet one or more of the timeliness standards, a penalty of \$.50 per failed standard for every enrollee as of the end of the month shall be assessed against OASYS. During the course of the examination, the examiners did not find, nor were they provided with, evidence that this penalty was paid for September 2002. During the exit conference, OASYS's explanation for the delay in payment was that the payment was pending legal review. Subsequent to the exit conference, OASYS provided a copy of a credit memo for the September 2002 penalty that indicated a credit was posted to the AR System in October 2002. This is also discussed under the Financial Examination section of this report.

CUSTOMER SERVICE

Customer Service Manual

OASYS provided the examiners with its customer service manual. The manual provided a description of workflow in the customer service department. The examiners found the manual to accurately describe the processes in place.

Internal Auditing

OASYS began internal audits in January 2002 to assure compliance with internal standards as well as WSHIP contractual standards. The examiners were provided with the internal customer service audits performed January 2002 through June 2002. Four (4) of the six (6) months reviewed met the OASYS standard of 85% accuracy for customer service representatives (CSR).

The following is a summary of the errors found during the internal audit process:

- Telephone number is not verified
- CSR not checking for duplicate inquiry before loading into computer system
- Telephone call not loaded in computer system within 24 hours
- Internal communications not being sent when necessary
- Caller not authenticated before release of information
- Providing inaccurate effective or termination dates of a member
- Disclaimer not being quoted after giving benefits
- Entering inaccurate codes in the computer system
- CSR not entering responses in the text field of the computer system
- CSR entering inaccurate subject information
- Inaccurate responses provided to the caller
- Courtesy and empathy not displayed to the caller

Customer Service Review

There are six (6) customer service representatives that staff the telephones. In addition to WSHIP, these CSRs also take calls for Colorado and Iowa. Each CSR completes a three-week training program. The CSRs are trained on the computer systems, eligibility, forms, HIPAA requirements, and benefits. Every new CSR has a 30-, 60-, 90-, and 180-day review. Telephone calls are randomly monitored to assure accuracy and demeanor with the consumer. The internal audits are placed into each CSRs personnel file and are forwarded to management to assure that contractual agreements are being met.

The following Customer Service Standard failed:

#	Customer Service Standard	Reference
1	The plan administrator shall maintain accuracy of customer service telephone inquiry information at a percentage of 95% or greater.	Per the Terms of Administrative Services Agreement

The examiners monitored 26 telephone calls over a period of two (2) days. The examiners noted two (2) customer service issues that were either in conflict with defined procedures or in violation of statute:

- A person called to inquire about eligibility with WSHIP and preexisting condition waiting periods. The person was pregnant, had applied to another carrier, and was expecting to be rejected by that carrier for other medical conditions. The CSR stated that there is a six-month pre-existing condition waiting period that includes pregnancy. It was not communicated to the caller that the pre-existing condition waiting period applies to delivery of the baby, but not to prenatal care as stated in RCW 48.41.110(6).
- A provider called to inquire about a participant's eligibility for coverage. The caller stated that she was in the process of assisting the participant with obtaining a certificate of coverage from the participant's prior carrier in order to have the pre-existing condition waiting period waived. The CSR stated that once OASYS received the certificate, an appeal would need to be filed by the participant. The response given by the CSR creates additional and unnecessary steps for the participant. OASYS policy and procedures state that credit for preexisting conditions will be given upon receipt of proper documentation.

Subsequent Event: Effective July 1, 2002, WSHIP required training and procedures to ensure the accuracy of customer service inquiries. Contractual performance standards and penalties were implemented at that time. The training program was moved to OASYS's compliance department in April 2003. The creation of a formal training program, including extensive documentation of core processes in training manuals for staff, for all operational areas was initiated. Every new customer service representative is subject to a 90-day review. All employees are subject to 180-day and annual reviews

FINANCIAL EXAMINATION REPORT

PERFORMANCE STANDARDS

The Administrative Services Agreement between WSHIP and OASYS, effective July 1, 2002, includes the following Performance Standards:

- Ninety percent (90%) or more of all clean claims are processed within fifteen (15) days of receipt. A "clean claim" is one that requires no additional information or documentation prior to adjudication;
- Ninety-eight percent (98%) or more of all clean claims are processed within thirty (30) calendar days of receipt.

Each month, OASYS prepares a "Clean Claims" Report that identifies the number of claims paid within fifteen (15) days and thirty (30) days. These reports indicate that OASYS did not meet the Performance Standards in July 2002 and September 2002 and that OASYS exceeded the Performance Standards in August 2002, October 2002 and November 2002.

To verify the accuracy of the "Clean Claims" Reports, the examiner obtained an Incurred Claims data file of all claims paid in July, August and September 2002. Calculations based upon this data file indicate OASYS did not meet the Performance Standards in July, August and September 2002. In each of these months, there were discrepancies in the number of clean claims paid within fifteen (15) days, number of clean claims paid within thirty (30) days and the total number of clean claims paid during the month.

OASYS does not include a status field in its data files that identifies each paid claim as clean or unclean, nor does OASYS have the capability to add this status field to historical paid claims records. Without this status field, it is not possible to audit and verify the accuracy of the "Clean Claims" Reports. This is a violation of RCW 48.05.280 which requires carriers to ensure that they keep full and adequate accounts and records of their affairs.

PAYMENT OF PERFORMANCE STANDARD PENALTY

The Administrative Services Agreement between WSHIP and OASYS, effective July 1, 2002, includes the following Performance Incentives for exceeding the Performance Standards and Penalties for failure to meet the Performance Standards:

- If for any month OASYS meets all accuracy standards and timeliness standards, a performance incentive of one dollar (\$1) for every Enrollee as of the end of the month shall be paid to the OASYS;

- If for any month OASYS fails to meet one or more of the timeliness standards, a penalty of \$.50 per failed standard for every Enrollee as of the end of the month shall be assessed against OASYS.

The examiners reviewed records for July 2002 through September 2002 to determine if the Administrator was eligible to receive a Performance Reward or was required to pay a Performance Penalty; and also to determine when the reward or penalty was settled. The examiners review was inconclusive because they were not able to recreate the numbers submitted to the Plan by the Administrator to substantiate the accuracy of the standards reported. Because of this, the tests run against the performance standards are based only on the calculations performed by the Administrator and are unverified by the examiners. The following comments pertain to the process only and do not verify any numbers.

The Monthly Invoices submitted by OASYS for August 2002, October 2002 and November 2002 included the Performance Incentive of one dollar (\$1) for every Enrollee for each respective month. The examiners found that OASYS was collecting the Performance Reward within one month of earning the Reward. For Performance Penalties, the examiners found that the July 2002 penalty was included with the March 2003 invoice, and the September 2002 penalty was posted to the accounts receivable ledger system in October 2002. The examiners requested that OASYS provide them with proof that the September 2002 penalty was settled, but this documentation was never provided.

The Executive Director of WSHIP approved the payment of these monthly invoices even though the penalties were not included. This is a violation of the Administrative Services Agreement.

Subsequent Event: During the Exit Conference, OASYS indicated that payment of the penalties was delayed pending a review by its Legal Department. Subsequent to the Exit Conference, OASYS provided copies of Credit Memos for the July 2002 and September 2002 penalties. The July 2002 Credit memo was issued January 14, 2003 and was included in the February 2003 Monthly Invoice. Payment of the February 2003 Monthly Invoice was posted April 1, 2003. The September 2002 Credit Memo was issued October 11, 2002 and was posted to Accounts Receivable Account No. 179432 on October 31, 2002. No documentation showing when the Accounts Receivable balance was settled was provided by OASYS as requested.

PREPARATION OF MONTHLY INVOICES BY ACS AND OASYS

Each month, ACS prepares a Monthly Invoice that itemizes the charges for services provided to WSHIP. The July 2002, August 2002 and September 2002 Monthly Invoices each included an incorrect charge of \$10,123.00 for Recurring Charges. The overcharge was discovered and corrected in October 2002.

REVIEW OF MONTHLY INVOICES BY WSHIP ADMINISTRATOR

Each month, the Executive Director for WSHIP reviews the Monthly Invoices and authorizes payment to OASYS. The incorrect charges included in the July 2002, August 2002 and September 2002 Monthly Invoices were not noted during the review process and OASYS was overpaid these amounts.

HISTORICAL DATA RECORDS

OASYS provided the examiners an Incurred Claims Paid data file. The data file was reviewed to determine the level of accuracy and level of reliance for purposes of the examination.

- The review noted six (6) transactions with incurred dates as of the years 2030, 2040 and 2070.
- There were 187 transactions with blank fields that should have contained the Plan ID Number.

When these transactions were compared to OASYS's on-line system during the on-site review, the errors were not present. The examiner has concluded that OASYS has the ability to change its historical data files. When asked if there were formal procedures for correcting historical data files, the response was that there is no policy in place to make this correction.

INSTRUCTIONS

	INSTRUCTIONS – Market Conduct	PAGE #
1	The Board must submit to the OIC any amendments to the Plan of Operation as the amendments are adopted.	10
2	The Plan must ensure that the existence of the pool is advertised to the public in general and rejected applicants in particular.	13
3	The Plan must require the administrator to regularly audit and reconcile its premium collection accounts. Audit and reconciliation results are to be reported to the Board.	23
4	The application form must be revised to clearly describe that full, non-discounted premium is required with application and that discounted premium will be effective <u>after</u> an applicant is approved for the premium discount.	25
5	The board is instructed to implement performance standards to assure accuracy and timeliness of premium collection and billing practices conducted by the administrator.	23
6	The Board must take steps to ensure that claims are processed in a timely manner. The administrator is instructed to process claims in a timely manner and pay penalties to WSHIP when performance standards are not met.	32
7	The Board must direct the administrator to implement training and procedures to assure accuracy of customer service telephone inquiries.	34
	INSTRUCTIONS – Financial	
8	The Board must direct the administrator to track and maintain historical data files that identify each paid claim as either clean or unclean for purposes of measuring performance standards.	37
9	The Board is instructed to review the monthly invoices prepared by the administrator to determine if incentive payments and penalty deductions have been accurately and appropriately included in the invoice, per the Administrative Services Agreement. No payments are to be made until this step has been taken and appropriate documentation has been reviewed.	37
10	RCW 48.41.050(3) directs the board to establish a procedure to track and archive all financial transactions. The Board is instructed to implement procedures to track all changes to historical data files, including management oversight and documentation of approval. Such procedures shall be formally documented in writing.	36

	INSTRUCTIONS - Financial	
11	The Administrative Services Agreement bases performance standards on clean and unclean claim statistics. The administrator is not able to ascertain if a claim is clean or unclean from current records. The Board is instructed to require the administrator to maintain records in a format that can be tied back to the performance standard requirements.	35

RECOMMENDATIONS

	RECOMMENDATIONS – Market Conduct	PAGE #
1	It is recommended that procedure manuals be updated to reflect that participants may contact the OIC at any time.	11, 17, 20
2	It is recommended that the administrator respond to communications from the OIC within 15 business days and with the substantial information requested in the inquiry. This will be a requirement as of 4/6/03 when the new Plan of Operation becomes effective.	17
3	It is recommended that the board conduct periodic audits of its health care network and pharmacy service contractors to assure that contractual obligations are met.	25
4	Currently, historical files cannot identify clean and unclean claims. Because of this deficiency the administrator is not able to determine with certainty that the administrator met the performance requirements set forth in the Administrative Services Agreement. The Board should require that the administrator provide the detail used to determine if performance standards are met or failed.	37
5	It is recommended that the Board continue to look for a member to represent the commercial disability market. Although the current make-up of the Board is within the definition in the statute, this does not relieve the Board of its responsibility to diligently seek members from the groups described in RCW 48.41.040(2).	9
6	It is recommended that the Executive Director review and approve all pharmacy benefit manager billing statements.	27

SUMMARY OF MARKET CONDUCT STANDARDS

Plan Operations and Management:

#	STANDARD	PAGE	PASS	FAIL
1	The Board of Directors is selected as required by statute. Reference: RCW 48.41.040(2)	9	X	
2	The board shall submit to the commissioner a plan of operation for the Pool and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Pool. Reference: RCW 48.41.040(4)	10		X
3	The plan of operation contains all required provisions. Reference: RCW 48.41.050	9	X	
4	The board selects an administrator to administer the Pool through a competitive bidding process. The administrator performs duties as assigned by the board. Reference: RCW 48.41.080	9	X	

General Examination Findings:

#	STANDARD	PAGE	PASS	FAIL
1	The Company and its representatives do business in good faith, and practice honesty and equity in all transactions. Reference: RCW 48.01.030	11	X	
2	Every person being examined, including its officers, employees, and representatives, must facilitate the examination process by providing its accounts, records, documents, and files to the examiners upon request. Reference: RCW 48.03.030(1)	11		X
3	The Company may not discourage members from contacting the OIC and may not discriminate against those members that do contact the OIC. Reference: WAC 284-30-572(2)	11, 17, 20	X	

Advertising:

#	STANDARD	PAGE	PASS	FAIL
1	The plan shall develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment, and maintain public awareness of the plan. Reference: RCW 48.41.050(8)	13		X

#	STANDARD	PAGE	PASS	FAIL
2	The administrator shall prepare a brochure outlining the benefits and exclusions of the Pool policy in plan language and make the brochure available to participants and potential participants. Reference RCW 48.41.110(2)	13	X	

Complaints:

#	STANDARD	PAGE	PASS	FAIL
1	The plan of operations establishes procedures under which applicants and participants may have grievances reviewed by an impartial body and reported to the board. Reference: RCW 48.41.050(9)	17	X	

Rate and Form Filing:

#	STANDARD	PAGE	PASS	FAIL
1	The board shall establish appropriate rates, utilizing appropriate risk factors in accordance with established actuarial underwriting practices under RCW 48.44.022 and RCW 48.46.064. Reference: RCW 48.41.060(1)(d)	19	X	
2	All policy forms issued by the Pool shall be filed with and approved by the commissioner before they are used. Reference: RCW 48.41.130	19	X	
3	Rates may not change except on a class basis. The Pool's right to change rates must be clearly disclosed in the policy. Reference: RCW 48.41.160(2)	19	X	

Contracts and Member Handbooks:

#	STANDARD	PAGE	PASS	FAIL
1	The Pool shall offer one or more care management plans of coverage. Reference: RCW 48.41.110(1)	19	X	
2	Plan benefits shall include the described minimum coverage. Reference: RCW 48.41.110(3)	19	X	
3	The board shall design and employ cost containment measures. Reference: RCW 48.41.110(4)	20	X	
4	The Pool benefit policy may contain benefit limitations, exceptions, and cost shares consistent with managed care products. No limitation, exception or reduction may be used to exclude coverage for any disease, illness, or injury. Reference: RCW 48.41.110(5)	19	X	

#	STANDARD	PAGE	PASS	FAIL
5	The contracts shall contain the deductible, coinsurance, out-of-pocket payment, and carryover requirements as defined. Reference: RCW 48.41.120	19	X	
6	Coverage for adopted and newborn children shall include care and treatment of medically diagnosed congenital defects and birth abnormalities. Reference: RCW 48.41.140(1)	19	X	
7	The board shall offer a medical supplement policy for persons receiving Medicare Parts A and B. Reference: RCW 48.41.150	20	X	

Underwriting:

#	STANDARD	PAGE	PASS	FAIL
1	The plan administrator shall administer eligibility functions relating to the Pool. Reference: RCW 48.41.080(3)(a)	22	X	
2	Any person who provides evidence within 90 days of a carrier's declination based on the standard health questionnaire is eligible for coverage. Reference: RCW 48.41.100(1)(a)	22	X	
3	Once a person is eligible for coverage under the Pool, that person will remain eligible until they no longer qualify for Pool coverage. Reference: RCW 48.41.100(1)(b)	22	X	
4	Eligibility for pool coverage is allowed because no carrier or surplus lines insurer offers other than catastrophic coverage in the applicant's county of residence. Reference: RCW 48.41.100(1)(c)	22	X	
5	A Medicare eligible person is eligible if they are rejected for a Medicare Supplement policy for the reason listed in the statute. Reference: RCW 48.41.100(1)(d)	22	X	
6	The Pool may not reject an individual for coverage based upon preexisting conditions but will impose a 6-month waiting period. The preexisting condition waiting period shall not apply to prenatal care. Reference: RCW 48.41.110(6)	23	X	
7	The Pool shall credit any preexisting condition waiting period for a person who was enrolled at any time during the 63-day period immediately preceding the date of application for the new plan. Reference: RCW 48.41.110(7)(a)	23	X	
8	If application is made as result of rejection, the date of application to the carrier, rather than to the Pool, should govern for purposes of determining preexisting condition credit. Reference: RCW 48.41.110(8)	23	X	

Policy Administration:

#	STANDARD	PAGE	PASS	FAIL
1	The plan administrator shall establish a premium billing procedure for collection of premiums. Billings shall not be more frequent than monthly. Reference: RCW 48.41.080(3)(b)	23	X	
2	Coverage will not terminate for a dependent child if he/she is developmentally disabled. Reference: RCW 48.41.140(2)	N/A		
3	The Pool is obligated to renew the policy until the individual becomes eligible for Medicare. Reference: RCW 48.41.160(1)	N/A		
4	Upon the death of the individual in whose name the policy is issued, every other individual covered under the policy may elect to continue coverage under the same or different policy. Reference: RCW 48.41.160(3)	N/A		
5	The plan administrator shall provide timely and comprehensive services for premium billing and collection. These services include rate calculation, enrollee billing, collection of premiums and account reconciliation. Reference: Terms of the Administrative Services Agreement	23		X

Claims:

#	STANDARD	PAGE	PASS	FAIL
1	The plan administrator shall administer claim payment functions relating to the Pool. Reference: RCW 48.41.080(3)(a)	31	X	
2	The plan administrator shall perform the described necessary functions to assure timely payment of benefits to covered persons under the Pool. Reference: RCW 48.41.080(3)(c)	32		X
3	The Pool will be the last payor of benefits whenever any other benefit is available. Reference: RCW 48.41.210	31	X	
4	The plan administrator shall maintain clerical accuracy of claims processed at a percentage of 95% or greater. Reference: Terms of the Administrative Services Agreement	31	X	
5	The plan administrator shall maintain financial accuracy of claims processed at a percentage of 98% or greater. Reference: Terms of the Administrative Services Agreement	31	X	

Customer Service:

#	STANDARD	PAGE	PASS	FAIL
1	The plan administrator shall maintain accuracy of customer service telephone inquiry information at a percentage of 95% or	34		X

	greater. Reference: Terms of the Administrative Services Agreement.			
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APPENDIX 1

Claims Standard #2:

Claims Standard #2:
The administrator shall perform the described necessary functions to assure timely payment of benefits to covered persons under the Pool. Reference: RCW 48.41.080(3)(c).

CLAIMS NOT PROCESSED WITHIN 30 CALENDAR DAYS

[illegible]



Kären Larson
Executive Director
P. O. Box 269
Bow, Washington 98232-0269
360/766-6336

September 4, 2003

RECEIVED
SEP 05 2003

James T. Odiorne, CPA, JD
Deputy Insurance Commissioner
Company Supervision Division

INSURANCE COMMISSIONER
COMPANY SUPERVISION

Re: Draft Report of Combined Financial & Market Conduct Examination

Dear Mr. Odiorne:

Enclosed is WSHIP's response to the OIC's "Draft Report of Combined Financial & Market Conduct Examination." Also included are attachments noted in the text of this response. I appreciate the opportunity to respond to the examiners' report and to comment on the facts as presented.

WSHIP's response includes new information that was mistakenly not provided to the examiners or that was not specifically requested at the time of the examination. Unfortunately, as I was not interviewed as a part of the examination, I was not able to provide clarification and additional information that is now included in this response.

The Combined Financial & Market Conduct Examination is the first time WSHIP has been audited by the Office of the Insurance Commissioner since WSHIP's formation in 1988. On behalf of the Board of Directors I want to express my appreciation to the OIC for the opportunity for WSHIP to improve the services it provides to enrollees, to correct operational problems that have been noted by the examination, and to assure compliance with the rules and regulations under which WSHIP is governed.


I am, however, concerned about the communication problems that existed between the OIC examiners and WSHIP's Administrator, OASYS, during the on-site visit in Indiana. I believe these problems are of the magnitude that they obstructed fact finding. 15 issues of disputed facts are cited in WSHIP's response to the OIC report.

I am hopeful that the additional information provided, along with electronic files being sent to the OIC by OASYS, will resolve all issues satisfactorily now, in the report response phase. If resolution of these communication problems is not to the OIC's satisfaction, I would like to request that your office and I confer prior to the issuance of a public report to clarify any remaining discrepancies.

I am available to discuss this response with you or the examiners in the coming weeks; however, I do have business travel scheduled so I am providing my cell phone number in case you cannot reach me at my office. These numbers are: office phone 360.360.6336; cell 360.319.5998. My assistant, Anne Mackie, will know my travel schedule and can always reach me. Her numbers are: office 360.734.2577; cell 360.739.0196.

I look forward to hearing from you.

Sincerely,

A handwritten signature in cursive script that reads "Karen Larson".

Kären Larson, Executive Director
Washington State Health Insurance Pool

Cc: Michael G. Watson, Chief Deputy Insurance Commissioner
Leslie A. Krier, AIE, FLMI, Chief Market Conduct Examiner
Patrick H. McNaughton, Chief Financial Examiner

Enclosure

WSHIP RESPONSE TO DRAFT COMBINED MARKET CONDUCT AND FINANCIAL EXAMINATION

September 4, 2003

PLAN OPERATIONS AND MANAGEMENT

OIC Page 9

The following Plan Operations & Management Standard passed with comment:

#	Plan Operations & Management Standard	Reference
1	<p>The Board of Directors is selected as required by statute.</p> <p><i>RESPONSE: WSHIP believes the facts are not correctly reported; specifically the statements at the top of page 10 "The current elected members consist of three HCSC members and one HMO member. One of the HCAC members works for a company that has an affiliate company which writes disability insurance in Washington state." David Toomey is employed by Aetna Life Insurance Company, a commercial insurer licensed in the state of Washington as a disability carrier. He represents disability carriers on the WSHIP Board of Directors.</i></p>	RCW 48.41.040(2)

OIC Page 10

The following Plan Operations & Management Standard failed:

#	Plan Operations & Management Standard	Reference
2	<p>The board shall submit to the commissioner a plan of operation for the Pool and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Pool.</p> <p><i>RESPONSE: WSHIP believes the facts may not be correctly reported. Reference is made to the statement on OIC page 10 "Changes to WSHIP operations from 1999 until 2002 were not submitted to the OIC as an amendment to the Plan of Operation. " The minutes of the April 5, 2001, WSHIP Board of Directors meeting (as submitted to the OIC as part of this Market Conduct Examination) indicate that Bill Hagens, the OIC WSHIP Board representative at the time, requested that copies of the revised Plan of Operations and Bylaws (which were approved at that meeting) be submitted to Jon Hedergard at the OIC. April 2001 was a period of transition between Executive Directors and the WSHIP Board was operating without staff. This finding was not raised at the OIC Exit Interview March 18, 2003; and therefore, we are not prepared at this time to provide a copy of the communication mentioned above that may have been submitted to Jon Hedergard. We are currently contacting former board members to locate a copy of the communication that was to have been submitted to the OIC.</i></p>	RCW 48.41.040(4)

GENERAL EXAMINATION STANDARDS

Reference is made to the following sentences from the second paragraph of the draft report: "Monthly performance was reported to the Board, but the Board did not appear to require back up documents, nor did it follow up on issues that were out of compliance with the Agreement. This practice appears to be a conflict of interest on the part of the Administrator, which was evaluating its own performance and reporting those results to the Board. The practice also appears to reflect the Board's failure of its fiduciary duty by accepting the results without any type of audit to prove the numbers."

RESPONSE: WSHIP believes the facts are not completely reported. It is true that the Board does not require back up documents, however Ernst & Young was asked to conduct a review of the performance reporting that was provided to the WSHIP board for 2002. They tested the standards specified in the Contractual Levels of Service and found no exceptions. This was reported to the Board at the annual meeting on March 6, 2003. At WSHIP's request, E&Y has provided a letter which documents the findings provided to the Board at the March 6, 2003, board meeting. That letter is attached for the OIC's reference. (See Attachment A.)

In addition, the Board does follow up on issues out of compliance with the Agreement. OASYS representatives are required by the Board to attend every Board meeting either via teleconference or in person. There is an Operations Report as an agenda item at each meeting, and the Board questions the Administrator regarding any known issues. Effective with the July 1, 2002, contract, the Administrator is required to provide a written corrective action plan for any contractual performance standard out of compliance for two successive months. The Board also required that the July 1, 2002, contract allow for termination for cause if WSHIP is dissatisfied, in its sole discretion, with OASYS' performance. A back-up contract was executed with the runner-up bidder during the last RFP process, for use in the event the Board determined that the OASYS contract should be terminated prior to the end of the first contract year. In the first six months of the contract, OASYS performance was much improved. However, in the second six months of the year, OASYS missed the 15-day timeliness every month and the 30-day timeliness in May and June. The Board has also been dissatisfied with OASYS performance with respect to premium billing accuracy and timeliness, and with OASYS efforts to address billing errors identified in December in a timely manner. As a result, the Board has directed that a Request for Proposal (RFP) be issued to parties interested in becoming the WSHIP administrator.

WSHIP does not believe OASYS' internal auditors' performance reporting on OASYS operations staff indicates a conflict of interest. All documentation for performance reporting is generated from system reports and internal audits. The operational business units do not know the performance results until the Compliance Department provides the reports. Further, the Compliance Department is separate from Operations and is independent to all other areas throughout the organization. The Director is a CPA and CFE. WSHIP believes that this reporting can be relied upon so long as periodic independent audits are conducted.

OIC Page 11

The following General Examination Standard passed with comment:

#	General Examination Standard	Reference
3	The Company may not discourage members from contacting the OIC and may not discriminate against those members that do contact the OIC. <i>RESPONSE: See WSHIP Response page 6 of this document.</i>	WAC 284-30-572(2)

OIC Page 11

The following General Examination Standard failed:

#	General Examination Standard	Reference
2	<p>Every person being examined, including its officers, employees, and representatives, must facilitate the examination process by providing its accounts, records, documents, and files to the examiners upon request.</p> <p><i>RESPONSE: WSHIP believes the facts are not correctly reported.</i></p> <p><i>(1) The narrative for this standard (as reported in the OIC report, page 11) gives as an example of a lack of cooperation that the Administrator would not release claim file information to the examiners because the OIC would not sign a confidentiality agreement. WSHIP believes all appropriate claims data as requested by the OIC examiners was made available to them by OASYS. The examiners, however, were not allowed unfettered access to the premises, nor were they allowed access to claims data for plans or members not included within the scope of the audit. By requesting a signed confidentiality agreement from the OIC examiners, OASYS was not intending to be "difficult to work with" as stated in the OIC report. OASYS is a company that provides administrative services to numerous health plans and is obligated by HIPAA regulations to protect the privacy of that information. A statement from WSHIP's Privacy Director is submitted with this response. It states WSHIP's understanding of why OASYS did not allow the OIC examiners access to non-WSHIP related information. (See Attachment B.)</i></p> <p><i>(2) The "Subsequent Event" (as reported in the OIC report, page 11) is in error due to an incorrect statement by WSHIP's Executive Director in her email to Michael Arnis dated August 7, 2003, in which she said the examiners "had full access to data bases (as opposed to the actual claim system) limited to WSHIP enrollee information." The examiners did have access to the actual WSHIP enrollee data, as follows:</i></p> <p><i>(2.a) The claims data which the OIC examiners reviewed was in MCAS (the claims core processing system).</i></p> <p><i>(2.b) The OIC examiners were also provided with a claims data dump (incurred claims data file), which was a separate data base of claims created based on their specifications.</i></p> <p><i>(2.c) It is important to note that OASYS has never provided direct system access to external examiners before. OASYS made special accommodation for the OIC examiners so that they would have the full</i></p>	RCW 48.03.030(1)

<p>access they needed, while protecting the privacy of clients not included in the WSHIP audit. The examiners were provided with the same security access to MCAS as a Customer Service Representative who has access to the WSHIP region. That is, they could view most WSHIP screens in MCAS, but could not make any edits to the claims data. The examiners were not able to view certain items, such as the "flag" which identifies a claim as clean or dirty, as this requires the security level access of a programmer.</p> <p>(2.d) OASYS requires all visitors, including auditors and examiners, to sign a confidentiality statement due to incidental disclosure of account information not relevant to their specific audit or examination. Refusal to sign this statement did result in restriction of examiner access to the claim processing environment (operational areas) to observe claims operations, processing, and work flow.</p> <p>(2.e) An OASYS Operations Manager sat with both OIC examiners during the on-site audit and demonstrated how to access screens that track changes to historical data in the MCAS system. Subsequent to the on-site audit by the OIC examiners, OASYS sent print outs of the audit trail for claims data reviewed at the time of the on-site audit that demonstrate that if/when data is changed in the system, there is an audit trail of what changes were made, when and by whom.</p> <p>(3) As agreed in an August 28, 2003, teleconference between the OIC examiners, WSHIP, and OASYS an additional data file of the claims data audited will be made available to the examiners in electronic format. This file will provide the "clean/dirty" indicator not available in the original report provided. OASYS had previously offered to address this need by providing the assistance of a programmer level person to assist with access to screens that included the "clean/dirty" indicator, so that the examiners could review a statistically significant sample of claims as a way to confirm that OASYS contractual level of services reports were accurate. The reason this file was not offered during the on-site audit is because OASYS staff only learned during the teleconference that the examiners had the technical expertise to be able to make sense of it.</p>	
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OIC Page 13

The following Advertising Standard failed:

#	Advertising Standard	Reference
1	<p>The plan shall develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment, and maintain public awareness of the plan.</p> <p><u>RESPONSE: WSHIP failed to submit all documentation related to this item in the report submitted to the OIC November 19, 2002. These additional items include:</u></p> <p>(1) In its "Carrier Instructions" document, WSHIP instructs all carriers to inform applicants who are rejected for individual coverage of the availability of the WSHIP plans and to provide WSHIP applications and a benefit brochure to each rejected applicant. (See Attachment C.)</p>	RCW 48.41.050(8)

- | | |
|---|--|
| <p>(2) Carriers are required to report monthly to WSHIP the rejected applicant names and addresses, so that WSHIP can verify the number of rejected applicants and do follow-up communications with these people. Because of this reporting process, we have reason to believe the carriers are complying with WSHIP's instructions to send WSHIP application materials to rejected applicants. (See Attachment D.)</p> <p>(3) In 2001 WSHIP conducted a survey of rejected applicants in an attempt to verify that rejected applicants were aware of the Pool and to learn why some rejected applicants were not enrolling in WSHIP. (See Attachment E.)</p> <p>(4) WSHIP publicizes information about its benefit plans and application process through a WSHIP Advocates group that meets periodically. During the audit period a WSHIP Board consumer representative attended these meetings regularly, and the Executive Director attended when invited by the group. This group includes representatives from Evergreen Health Insurance Program, Kidney Disease Program, Lifelong AIDS Alliance, Northwest Kidney Centers, National Organization of Health Law Advocates, SHIBA, Washington Citizen Action, Washington Coalition of Citizens with Disabilities, Washington Health Foundation and others.</p> <p>(5) A website link exists on the Office of the Insurance Commissioner's website to the WSHIP website, thus making information accessible to people who access the OIC website. (See Attachment F.)</p> <p>(6) The narrative for Advertising Standard #1 includes the statement "A formal plan to inform and maintain awareness of the Pool is not in place." The WSHIP Board approved a recommendation for carrier reporting and WSHIP outreach to health screened individuals at its December 7, 2000, meeting. (See Attachment G.)</p> | |
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COMPLAINTS

OIC Page 14-16 Complaints

The OIC examiners correctly state that the primary reasons for the delays in response are staffing issues and scanning to incorrect queues. OASYS took steps during June of 2001 and July of 2002 to address these issues by splitting the BPO Units and adding staff. Queues and work flow issues were also addressed during this time period.

Reference is made to a statement made on page 16, under OIC complaints "when asked to provide a log of complaints received from the OIC, OASYS responded that this information is not tracked." This is not entirely correct. On WSHIP's behalf OASYS, during the examination period, maintained a log of appeals and OIC complaints. However, they were not separately identifiable. Since this issue has arisen, separate logs have been maintained. Since the OIC site visit at OASYS, internal audits for OIC complaints have been initiated. Additionally, the internal audit programs have been updated to comply with the new WACs, which became effective on April 6, 2003.

OIC Page 17

The following General Examination Standard passed with comment:

#	General Examination Standard	Reference
3	<p>Members may not be discouraged from contacting the OIC and discrimination against those members that do contact the OIC is prohibited.</p> <p><i>RESPONSE: Enrollees are free to contact the OIC at any time, and WSHIP has never indicated otherwise in its printed policies or through its customer service contacts with enrollees. Language that existed in earlier versions of WSHIP's Grievance Procedure (in which the OIC was included as the third level of appeal) was never intended to disallow immediate contact with the OIC by an enrollee. This procedure was included in contract forms filed with and approved by the OIC prior to use. A representative of the OIC is a member of the Board Appeals and Grievances Committee that heard grievances as a part of the second level of the old procedure.</i></p>	WAC 284-30-572(2)

OIC Page 19

The following General Examination Standard passed with comment:

#	General Examination Standard	Reference
3	<p>Members may not be discouraged from contacting the OIC and discrimination against those members that do contact the OIC is prohibited.</p> <p><i>RESPONSE: See comment on WSHIP Response above.</i></p>	WAC 284-30-572(2)

UNDERWRITING Underwriting File Review

OIC Page 21

Reference is made to this statement in the third paragraph: "The examiners determined that the reason for long delays in processing applications occurred because the administrator had only one enrollment specialist to process applications. If that person was absent, the work would not get done."

RESPONSE: The primary cause of timeliness delays during the audit period was due to the lack of complete applications. A high percentage of applications required some form of follow-up with the applicant. (See Applications Pending @ Month End on the WSHIP Application Statistics report, Attachment H.) WSHIP improved the application form and application process, which has reduced the delays caused by applicants providing incomplete information. In addition, WSHIP has reduced the amount of time allowed for applicants to provide any required information that was not submitted with the original application form, in order to speed up the process. At the time of the audit there was no back-up staffing for the enrollment function. This situation has been corrected.

The following Policy Administration Standard failed:

#	Policy Administration Standard	Reference
5	<p>The plan administrator shall provide timely and comprehensive services for premium billing and collection. These services include rate calculation, enrollee billing, collection of premiums and account reconciliation.</p> <p><i>RESPONSE:</i></p> <p><i>In June of 2001 and July of 2002 OASYS split the BPO Units and added staff. Staffing, workflow, and internal communication issues were also addressed during this time period.</i></p> <p><i>As it relates to the error noted on page 23 bullet #5 of the report section, some critical information is not reflected. This member became effective with WSHIP in 1992. OASYS was not the Plan Administrator at that time. The previous administrator had the member's billing account set up for a third party to pay premiums. This third party received the refund due the member's estate. The refund check was not issued until the death certificate was received, which was 3 months later. The check was returned to OASYS and later voided because the member moved without providing a new address. The check was reissued once the new address was identified.</i></p> <p><i>WSHIP and OASYS have agreed to institute contractual audit standards for billing. OASYS has audited all known billing errors, is reimbursing WSHIP for any outstanding amounts, and is notifying all enrollees with outstanding balances that their coverage will not be terminated nor will they be sent to collections for failure to pay back balances owing due to billing errors. OASYS is currently re-reviewing every WSHIP account and will report findings to the Board. Additionally, OASYS' internal auditors have been conducting Billing Audits since January 2003. The audit programs were submitted to WSHIP for review, and the audit results are reported with the contractual levels of service on a monthly basis. Further, OASYS' internal auditors are performing a comprehensive review of monthly billing activity at the request of WSHIP.</i></p> <p><i>However, WSHIP is very dissatisfied with the length of time it took OASYS to address these issues. This is a major reason for its decision to issue an RFP.</i></p>	Per Terms of the Administrative Services Agreement

"The application does not state that the prospective member must pay the NON-DISCOUNTED premium amount."

RESPONSE: WSHIP's application forms were revised in 2002 and again in April 2003. Improvements to information about low income discounts were made in the Plans 1 & 3 forms and include: (1) a statement in

the "Application Checklist" that reads: "NOTE: If you are applying for the low income discount, you first must pay the amount due for one month's premium in order to activate your coverage." (See Attachment I.); (2) Rate Tables appearing in the current WSHIP Plans 1 & 3 applications state: "You Must Apply and be Approved to Qualify for the Low Income Discounts Below." (See Attachment J.)

ADMINISTRATIVE CONTRACTS

OIC Page 25

The OIC report states: "However, the examiners could not rely on the integrity of the data used to measure performance and were unable to confirm the figures reported to the Board of Directors."

RESPONSE: WSHIP believes the facts are not correctly reported. (See WSHIP Response pages 3 and 4.)

OIC Page 25

The OIC report states: "Payment to FCN is based on a percentage of network savings."

RESPONSE: WSHIP believes the facts are not correctly reported. Exhibit B of the FCHN contract, submitted to the OIC as part of this Market Conduct Audit, states: "FCHN will be paid based on a percentage of the network savings. The payment is calculated and paid monthly as 20% of the difference between the provider billed charge and the FCHN contract amount not to exceed \$3.25 per member per month." The WSHIP Executive Director reviews the monthly billing statements, compares them to the number of enrollees and multiplies by \$3.25; a percentage of network savings has never been paid because it has always exceeded this amount. (See Provider Discounts – PPO Plans 2001 and 2002 and April 2002 Plan Distribution Summary, Attachment K.)

OIC Page 26

The OIC report states: "Provantage bills WSHIP semi-monthly. Oversight consists of the WSHIP Executive Director's review and approval of the semi-monthly billing statements."

RESPONSE: WSHIP believes the facts are not correctly reported. The Executive Director has not reviewed the Provantage bills in the past; OASYS has performed this service.

CLAIMS

Claims Processing

OIC Page 26-27

RESPONSE: WSHIP believes the facts are not correctly reported.

- The narrative states "Electronic and paper claims for WSHIP's traditional plan and Medicare plans are sent directly to OASYS." OASYS does not process any electronic claims for WSHIP.
- The vertexing (data entry) work flow was not described correctly. The images of the claims that have been batched and scanned are downloaded to the Data Entry System. The vertexers (data entry staff) work with a split screen, with the image on one screen and the data entry template on

the other screen. As the information is entered into the template, the system automatically validates the procedure and diagnosis codes. The vertexer is presented with validation screens when they key the member and provider numbers to ensure that the correct member and provider are selected for the claim (based on criteria such as TIN, address, DOB, and effective dates). The system also validates that the total charges equal the sum of all detail lines entered. The vertexer can reject a claim within the system if it is missing information. A "reject" report is run daily and appropriate actions are determined. There are currently two vertexers who handle WSHIP, CoverColorado, and Iowa.

- The claims processing work flow was not described correctly. If all information required to adjudicate the claim is present and there are no outstanding issues to resolve (COB and/or Medical Necessity), then the claim will auto-adjudicate. An image of the claim is stored in the member's and provider's electronic folders. Claims that do not auto-adjudicate are downloaded to work queues for the Claims Specialists to resolve. The system applies benefits (deductibles, coinsurance, benefit limits, and/or out of pocket maximums). The Claims Specialists apply a COB, routes for medical review if necessary, verifies the accuracy of the data, and resolves all outstanding pends. Once completed, the claim is released for payment. There are 2 full-time Claims Specialists dedicated to processing WSHIP claims.
- It is true that 17% of WSHIP claims are auto-adjudicated. However auto-adjudicated claims are not the only claims that meet the definition of "clean". The 4th paragraph on page 27 of the audit report implies that this is the case. Approximately 50-60% of all claims submitted during the audit period were "clean" for the purposes of measuring the contractual standard.
- The approval of claims, by supervisory level, is incorrect. The OASYS High Dollar Claims Policy is attached for this review (See Attachment L.)
- Claim payment checks are not printed nightly. During the examination period, they were printed on Tuesdays and Thursdays. At this time, they are printed on Mondays, Wednesdays, and Fridays. Checks are mailed within 36 hours of the check print run.

OIC Page 28

Internal Claims Auditing

RESPONSE: WSHIP believes the facts are not correctly reported.

- The report does not accurately describe how OASYS/ACS internally audits tenured employees. ACS conducts internal audits of paid and denied claims for all accounts on a post-payment basis. The internal standard is 95% for clerical accuracy and 98% for financial accuracy. Internal claims audit standards are monitored by the Compliance Department and account results are communicated to Management on a monthly basis. Unacceptable error rates are referred to the Quality Management Team for corrective action. Claims audits are performed weekly by a Senior Quality Assurance Auditor and conducted on a random sample basis. The percentage of production subject to audit can vary based on population variables including, but not limited to, claims processor experience, claim amount, and contract requirements. Given an experienced claims processor population, audits are typically performed at the statistically significant level. High dollar claims are included in the post-payment audit sample and all paid claims over \$75,000 are reviewed by the Senior Quality Assurance Auditor on a pre-payment basis.
- Claims audits for new employees are conducted at the 100% level until contract clerical and financial accuracy is achieved.

The following Claims Standard failed:

#	Claims Standard	Reference
2	<p>The plan administrator shall perform the described necessary functions to assure timely payment of benefits to covered persons under the Pool.</p> <p><i>RESPONSE: WSHIP believes the facts were not correctly reported. OASYS completed a thorough review of Appendix 1 provided by the OIC. Their findings, as noted on the updated Appendix 1 (Attachment M), were that 11 of the 172 claim files reviewed (6.4%) were not processed within 30 calendar days. Additionally, 8 of the 172 claim files reviewed (4.7%) were not processed within 60 calendar days. Regarding the September 2002 findings, 100% of clean claims were processed within the 15 and 30-Day contractual period. The reason for the different findings, relative to the OIC's 48 claims, is that most of these 48 claims in the timeliness sample were not "clean." These claims were either adjustments or dirty claims, neither of which is contractually required to be considered in the performance metrics.</i></p> <p><i>The examiners indicate that they did not find evidence that the penalty was paid for September 2002. An internal credit memo for this was issued on October 11, 2002, and has been attached to this report (See Attachment N.)</i></p>	RCW 48.41.080(3)(c)

CUSTOMER SERVICE

Internal Auditing

OIC Page 31-32

RESPONSE: WSHIP believes the facts were not correctly reported.

Summary of corrections regarding the Internal Auditing of the Customer Service Section:

- *The OIC report's summary of errors found during the internal audit process were for all state risk pool accounts, not just WSHIP.*

Customer Service Review

RESPONSE: WSHIP believes the facts were not completely reported.

Summary of corrections and clarifications regarding the Customer Service Review of the Customer Service Section:

- *Effective July 1, 2002, WSHIP requires training and procedures to ensure the accuracy of customer service inquiries, as well as performance standards and penalties.*
- *The Training Program was moved to the Compliance Department in April of 2003. Since that time, the creation of a formal Training program for all operational areas has been initiated. This includes extensive documentation of core processes in training manuals for staff.*
- *Every new CSR has a 90 day review. All employees have 180 and annual reviews.*

- WSHIP calls are reviewed based on a detailed audit program, not just accuracy and demeanor with the consumer. This comprehensive internal audit program commenced in January 2002, prior to the contract requirement. All audit documentation is attached for review. (See Attachment O.)
- Since the new contract became effective, OASYS has been in compliance with the standard set forth by WSHIP.

OIC Page 33

FINANCIAL EXAMINATION REPORT

PERFORMANCE STANDARDS

RESPONSE: WSHIP believes the facts are not correctly reported.

- The report is not titled the "Clean Claims" report. It is the Claims Timeliness Report (ASGEN64A01). The monthly report includes both non-developed (clean) and developed (dirty) claims.
- Clean claims could not have been identified in the incurred claims data file that the examiners reference for purposes of determining reporting discrepancies for clean claims. At the time of the OIC site visit, the "flag" denoting whether a claim was clean or dirty was only able to be viewed in MCAS (the claims core processing system). This "flag" was located in an auxiliary table, which only programmers had security authorization to view. Because fields located in the auxiliary table could not be downloaded into DataMart (the database used for the OIC's incurred claims data file), there was no way for the OIC examiner to determine whether a claim was clean or dirty by looking at the incurred claims data file. Confirmation of these claims in MCAS, with the assistance of a programmer (which OASYS offered but the OIC examiner declined to accept), would have been required. The Claims Timeliness Reports used to measure and report performance for the contractual standards are generated in MCAS where the "flag" field resides. Complete copies of these Claim Timeliness Reports, as well as all claims in the report population, were provided to the examiner. (In August 2003 MCAS Version 853 was released into production. This allows the "flag" field to be viewed by non-programming staff. Additionally, the "flag" field can now be downloaded into DataMart.)
- Subsequent to the OIC examiners' on-site audit, a teleconference was held August 28, 2003, with the OIC examiners, WSHIP, and OASYS during which it was agreed OASYS would provide an electronic file of the information requested.

In summary, WSHIP believes there is no violation of RCW 48.05.280.

PAYMENT OF PERFORMANCE STANDARD PENALTY

OIC Page 33-34

The narrative states in the final paragraph "The Executive Administrator of WSHIP approved the payment of these monthly invoices even though the penalties were not included. This is a violation of the Administrative Services Agreement."

RESPONSE: WSHIP believes the facts are not correctly reported. The Administrative Services Agreement specifies that payment of penalties and incentives shall be part of OASYS' monthly billing process. This does not necessarily require that penalties or incentives for a given month must be paid along with the invoice for that month's service. All penalties were billed and paid, once the performance had been reported to ACS and the credit approved. The invoice billing approval procedure has changed so that contractual

penalty and incentive payments are deducted from or added to the next invoice payment received after performance has been reported, whether or not they are correctly reflected on a given invoice.

OIC Page 34

HISTORICAL DATA RECORDS

RESPONSE: WSHIP believes the facts are not correctly reported.

Summary of clarifications regarding the Historical Data Records Section:

- *Future date errors noted in the claims dump are in the file because the date error is a permanent part of the claim history. As noted on the documents provided to the OIC, the vertexers (data entry staff) made a typographical error in keying the date. At the time of the audit, MACESS allowed an incorrect future date to be entered. If a date error was made by the vertexer, it would be noticed by the processor when the claim is processed in MCAS, as a prompt regarding the date error appears. Unless the date is corrected, the processor cannot continue to process the claim. Because the claim had not been paid at the time of the edit, there was no modification of a "historical" file.*
- *During the on-site audit, an OASYS manager demonstrated and trained the OIC examiners in how to view the historical screens on the claim system in order to see that changes are tracked in the system.*
- *In addition, the following information was mailed to the OIC: a copy of the imaged claim for each future date error, documents that demonstrate the future dates were typographical errors, the complete system audit trail of each claim from MCAS, and the Claim Detail Maintenance screen print which shows the date changes made in MCAS. With the release of MCAS Version 853, any future date error would reject and be noted in an exception file at the end of the business day. The claim file would be accepted into MCAS (from MACESS) but would require correction before the audit trail processes the claim(s).*
- *There were no changes made to the 187 historical data records as it relates to this OIC observation. The reason that the Plan ID numbers were not in the incurred claims data file (but were in MCAS) was that there was an error in the claims file when it was created. Plan ID information is only contained in the "header" lines and the programmer extracted the "detail" lines instead. OASYS offered to rerun the report, but OIC did not request that be done.*

	INSTRUCTIONS – Market Conduct	Page #
1	<p>The Board must submit to the OIC any amendments to the Plan of Operation as the amendments are adopted.</p> <p><i>RESPONSE: WSHIP will submit any amendments to the Plan of Operations to the OIC as soon as they are adopted.</i></p>	10
2	<p>The Plan must ensure that the existence of the pool is advertised to the public in general and rejected applicants in particular.</p> <p><i>RESPONSE: WSHIP will implement a Program of Public Information (described in detail below) that will include:</i></p> <ol style="list-style-type: none"> <i>1. Notifications to all rejected applicants from WSHIP about the availability of WSHIP benefit plan coverage.</i> <i>2. Public Service Announcements (PSA's) issued to news media</i> <i>3. Regular communications with advocate groups</i> <i>4. Agent communications</i> <i>5. Publication of a WSHIP publicity flier</i> <p><u><i>1. Notifications to all rejected applicants:</i></u> <i>WSHIP will do a mailing to each rejected applicant 30 days from rejection notice date to verify that the carriers have sent a WSHIP application packet (includes brochure and application). This mailing will include a response card that the recipient is asked to return to WSHIP. The card will allow them to (a) indicate that they have received a WSHIP application packet; or (b) request a WSHIP application if they have not received one. If a response is not received, a follow-up mailing and survey will be sent 60 days from rejection notice date.</i></p> <p><u><i>2. Regular communications with advocate groups:</i></u> <i>WSHIP will continue its communication with advocate groups, the WSHIP Exec. Director and a consumer representative of the Board. This will help to ensure that these groups are getting current information about WSHIP that they can pass on to their constituents. WSHIP will work with Evergreen Health Insurance Program, Kidney Disease Program, Lifelong AIDS Alliance, Northwest Kidney Centers, National Organization of Health Law Advocates, SHIBA, Washington Citizen Action, Washington Coalition of Citizens with Disabilities, Washington Health Foundation and others.</i></p> <p><u><i>3. Agent communications:</i></u> <i>In April 2003 WSHIP began a focused publicity effort with licensed insurance agents who are an important link for communication with potential WSHIP applicants. WSHIP board members prepared and presented a training workshop about WSHIP eligibility and application processes at the spring Washington Association of Health Underwriters conferences held in Spokane and Seattle. Agents who participated in these workshops have signed up to be listed in an Agent Directory that is distributed with each WSHIP application. Regular communications with agents will continue to ensure that they have the most recent information about WSHIP.</i></p>	13

	<p><u>4. Publication of a WSHIP publicity flier:</u> WSHIP will produce an easy to understand summary of WSHIP eligibility requirements and benefits and make this flier available at community centers, hospitals, and medical clinics.</p>	
3	<p>The Plan must require the administrator to regularly audit and reconcile its premium collection accounts. Audit and reconciliation results are to be reported to the Board.</p> <p><i>RESPONSE: The administrator will be required to regularly audit and reconcile its premium collection accounts and report results to the Board.</i></p>	22
4	<p>The application form must be revised to clearly describe that full, non-discounted premium is required with application and that discounted premium will be effective <u>after</u> an applicant is approved for the premium discount.</p> <p><i>RESPONSE: WSHIP is in the process of revising the application form and it will be filed with the OIC in the 4th quarter of 2003.</i></p>	22
5	<p>The Board is instructed to implement performance standards to assure accuracy and timeliness of premium collection and billing practices conducted by the administrator.</p> <p><i>RESPONSE: WSHIP will require enhanced billing standards and performance incentives and penalties to be added to the administrative services agreement. The audit programs will be submitted to WSHIP for review and the audit results reported to the Board with the contractual levels of services.</i></p>	22
6	<p>The Board must take steps to ensure that claims are processed in a timely manner. The administrator is instructed to process claims in a timely manner and pay penalties to WSHIP when performance standards are not met.</p> <p><i>RESPONSE: WSHIP has taken steps within its Administrative Services Agreement with OASYS to ensure timely claim processing – comprised of penalties for missing 15 and 30 day timeliness standards. WSHIP will require all claims (clean and dirty) to be processed within 60 days. WSHIP has also issued a Request for Proposal for administrative services to seek an administrator that can provide better service than WSHIP is currently receiving from OASYS.</i></p>	30
7	<p>The Board must direct the administrator to implement training and procedures to assure accuracy of customer service telephone inquiries.</p> <p><i>RESPONSE: WSHIP does require training and procedures to ensure the accuracy of customer service inquiries, as well as contractual performance standards and penalties.</i></p>	32
	INSTRUCTIONS – Financial	
8	<p>The Board must direct the administrator to track and maintain historical data files that identify each paid claim as either clean or unclean for purposes of measuring performance standards.</p>	33

	<i>RESPONSE: WSHIP does require its administrator to track and maintain historical data files that identify each paid claim as either clean or unclear for purposes of measuring performance standards.</i>	
9	<p>The Board is instructed to review the monthly invoices prepared by the administrator to determine if incentive payments and penalty deductions have been accurately and appropriately included in the invoice, per the Administrative Services Agreement. No payments are to be made until this step has been taken and appropriate documentation has been reviewed.</p> <p><i>RESPONSE: Section 3.02 of the Administrative Services Agreement addresses the payment of OASYS Administrative Fees. This section directs WSHIP to pay the administrative fee within 30 days of the OASYS bill. The Executive Director will not authorize payment of incentives until performance reporting is completed. Penalties will be deducted from administrative payments as soon as they are incurred.</i></p>	33
10	<p>RCW 48.41.050(3) directs the board to establish a procedure to track and archive all financial transactions. The Board is instructed to implement procedures to track all changes to historical data files, including management oversight and documentation of approval. Such procedures shall be formally documented in writing.</p> <p><i>RESPONSE: WSHIP does require that all financial transactions are tracked and archived. As a part of this, procedures for tracking all changes to historical data files, including management oversight and documentation of approval, will be maintained and formally documented in writing.</i></p>	34
12	<p>The Administrative Services Agreement bases performance standards on clean and unclear statistics. The administrator is not able to ascertain if a claim is clean or unclear from current records. The Board is instructed to require the administrator to maintain records in a format that can be tied back to the performance standard requirements.</p> <p><i>RESPONSE: WSHIP does require its administrator to track and maintain historical data files that identify each paid claim as either clean or unclear for purposes of measuring performance standards.</i></p>	33

Recommendations

Page 37

	RECOMMENDATIONS – Market Conduct	Page #
1	<p>It is recommended that procedure manuals be updated to reflect that participants may contact the OIC at any time.</p> <p><i>RESPONSE: Procedure manuals will be update to reflect that participants may contact the OIC at any time.</i></p>	11, 17, 19

2	<p>It is recommended that the administrator respond to communications from the OIC within 15 business days and with the substantial information requested in the inquiry. This will be a requirement as of 4/6/03 when the new Plan of Operation becomes effective.</p> <p><i>RESPONSE: Section 3.06 of the WSHIP administrative services agreement requires that the administrator perform its obligations in accordance with applicable state and federal law, therefore it is a requirement of the contract with OASYS that it respond to communications from the OIC within 15 business days and with the substantial information requested in the inquiry.</i></p>	16
3	<p>It is recommended that the board conduct periodic audits of its health care network and pharmacy service contractors to assure that contractual obligations are met.</p> <p><i>RESPONSE: Audits of the health care network and pharmacy benefits manager will be added to the 2004 WSHIP Board Schedule and Work Plan.</i></p>	24
4	<p>Currently, historical files cannot identify clean and unclean claims. Because of this deficiency the administrator is not able to determine with certainty that the administrator met the performance requirements set forth in the Administrative Services Agreement. The Board should require that the administrator provide the detail used to determine if performance standards are met or failed.</p> <p><i>RESPONSE: WSHIP does require its administrator to track and maintain historical data files that identify each paid claim as either clean or unclean for purposes of measuring performance standards, and provide any other detail required to determine if performance standards are met or failed.</i></p>	33
5	<p>It is recommended that the Board continue to look for a member to represent the commercial disability market. Although the current make-up of the Board is within the definition in the statute, this does not relieve the Board of its responsibility to diligently seek members from the groups described in RCW 48.41.040(2).</p> <p><i>RESPONSE: WSHIP will continue to endeavor to maintain member representatives of Health Care Services Contractors, Health Maintenance Organizations and Disability Carriers on its Board of Directors.</i></p>	9

WSHIP Response to OIC Market Conduct Examination Report

Attachments

Attachment	Description
Attachment A	Letter from Ernst & Young, August 21, 2003
Attachment B	Letter to Kären Larson from Sue Overstreet, Privacy Director, August 26, 2003
Attachment C	Carrier Instructions
Attachment D	Print screen of carrier reporting page on WSHIP website
Attachment E	Survey of Rejected Applicants, 2001
Attachment F	Print screen of OIC website that links to WSHIP website
Attachment G	Page 4 of WSHIP Board meeting minutes 12/5/00, WSHIP data reporting and outreach to health screened individuals
Attachment H	WSHIP Application Statistics Report
Attachment I	Application Checklist
Attachment J	Rate Tables
Attachment K	Provider Discounts – PPO Plans, 2001 and 2002 and Monthly Plan/Age Distribution Summary sample, April 2002 (sample)
Attachment L	OASYS High Dollar Claims Policy
Attachment M	Updated Appendix 1, OIC report
Attachment N	Internal credit memo
Attachment O	ACS Audit Procedures

August 21, 2003

Ms. Karen Larsen
Executive Director
Washington State Health Insurance Pool
P.O. Box 269
Bow, Washington 98232-0269

Dear Karen:

At the request of the Board of Directors of Washington Health Insurance Pool (WSHIP), we have performed the procedures enumerated below, which were agreed to by management of WSHIP, solely to assist the Board in evaluating the summary of the Contractual Levels of Service, as prepared and submitted to the Board by Affiliated Computer Services, Inc. (ACS). ACS is responsible for the preparation of the summary. The sufficiency of our procedures is solely the responsibility of those parties specified in this report. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

Ernst & Young reviewed certain documentation prepared by ACS in support of compliance with the performance standards outlined in WSHIP's contract with ACS. Ann Bingman, the Director of Contract Compliance and Client Accounting at ACS, provided us with the summary of the Contractual Levels of Service Reports for 2002 submitted to the WSHIP Board of Directors. We performed certain procedures on the reports by agreeing information to internal audit documentation and system-generated reports, as follows:

The Claims Timeliness for 15 and 30 days was agreed to system-generated Claims Timeliness Reports (ASGEN64A01). We selected random months and recalculated percentages and found no exceptions.

In order to test the Clerical and Financial Accuracy, we agreed percentages to the Monthly Internal Audit of Claims Reports. We clerically tested and recalculated percentages for random months and found no exceptions.

In order to test the Telephone (CSR) Accuracy, we agreed percentages to the Monthly Internal Audit of CSRs Reports. We clerically tested and recalculated percentages for random months and found no exceptions.

The Average Speed of Answer and Abandon Rates, related to calls from Members and Providers, were agreed to the Board Statistics File and the OHP Adjusted ASA tab maintained by the Contract Compliance Department. The ASA and Abandon Rate were tested by agreeing amounts to the OHP Web Trend Reports (based on Internet activity) and the BCMS Vu VDN Daily Phone System Reports. Additionally, we clerically tested and recalculated the statistics for random months. No exceptions were noted.

Overall, as we reported to the Board of Directors at its March 6, 2003 meeting, we found no exceptions on the Contractual Levels of Service Report, prepared by the Contract Compliance Department of ACS based on the procedures performed.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the summary of performance standards and Contractual Levels of Service Worksheet. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Board of Directors and management of Washington State Health Insurance Pool, and is not intended to be and should not be used by anyone other than these specified parties.

Sincerely,

A handwritten signature in dark ink, appearing to read "John S. Leemhuis", written in a cursive style.

John S. Leemhuis
Senior Manager

August 26, 2003

Ms. Karen Larson
Executive Director
Washington State Health Insurance Pool (WSHIP)
P.O. Box 269, Bow, WAS 98232-0269

Dear Ms. Larson:

Please see below the regulation text referenced on page 11 regarding Standard#2 of the Report of Combined Financial & Market Conduct Examination of August 13, 2003.

§ 164.512 Uses and disclosures for which consent, an authorization, or opportunity to agree or object is not required.

(d) Standard: uses and disclosures for health oversight activities.

(1) Permitted disclosures. A covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of:

- (i) The health care system;
- (ii) Government benefit programs for which health information is relevant to beneficiary eligibility;
- (iii) Entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or
- (iv) Entities subject to civil rights laws for which health information is necessary for determining compliance.

Washington State Health Insurance Pool

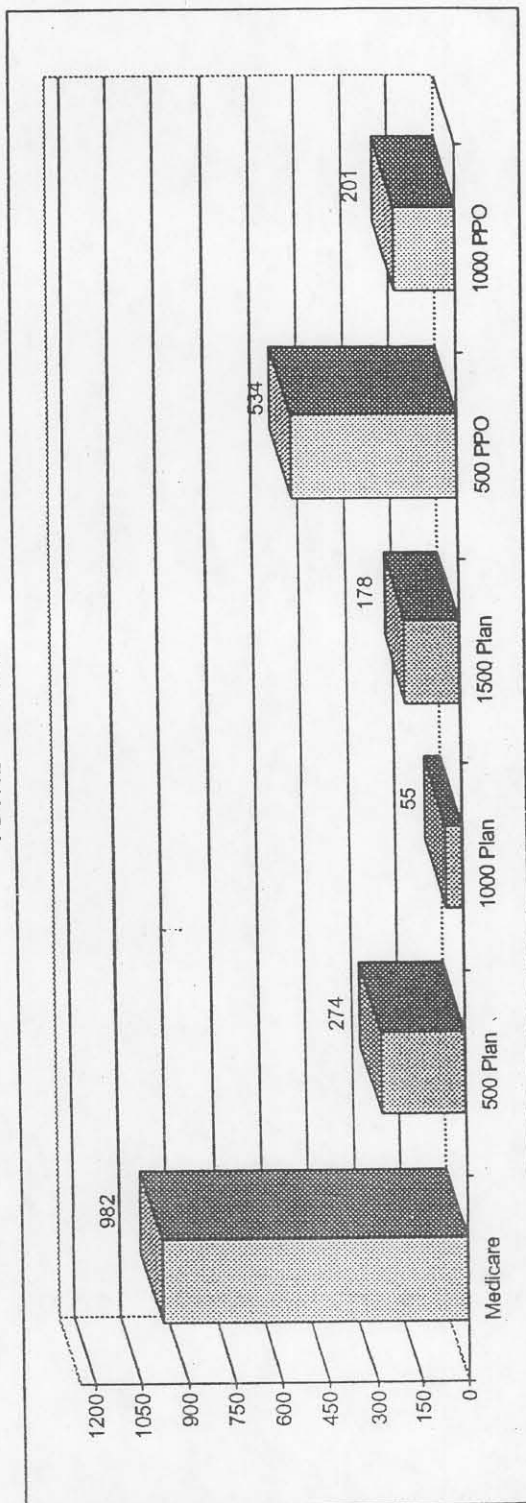
Non-Medicare / Medicare Plans

Plan / Age Distribution Summary

April 2002

Age	Non-Medicare Plans		Medicare Plan		PPO Plan	
	500	1000	Age	1500	500	1000
0-17	12	1	0-17	7	14	3
18-29	44	1	18-29	3	58	6
30-34	36	3	30-34	1	78	8
35-39	39	3	35-39	3	88	7
40-44	29	3	40-44	14	67	17
45-49	36	11	45-49	14	67	24
50-54	27	10	50-54	28	67	24
55-59	24	10	55-59	42	49	44
60-64	24	12	60-64	64	42	66
65-69	2	1	65-69	0	3	0
70-74	0	0	70-74	0	0	1
75-79	0	0	75-79	2	1	1
80-84	0	0	80-84	0	0	0
85-+	1	0	85-+	0	0	0
	274	55		178	534	201
				982		

TOTAL 2224



The total provider discounts in 2002 were \$1,660,870, compared to \$787,092 in 2001.

Provider Discounts - PPO Plans



Revised December 20, 2001

Instructions for the High-Risk Pool Questionnaire

General:

The Standard Health Questionnaire (SHQ) developed by the Washington State Health Insurance Pool (WSHIP) is the only health screening process permitted for non-Medicare individual medical plans sold to Washington State residents.

Insurance carriers can reproduce the Standard Health Questionnaire form. A PDF version is available on the WSHIP web site at www.onlinehealthplan.com. Any change in format must be authorized by WSHIP. Electronic interactive forms must be approved by WSHIP. Changes to the content of the questionnaire are not permitted. Carrier comments and questions regarding the use and content of the form should be addressed to the WSHIP Board office, P.O. Box 269, Bow, WA 98232-0269

Carriers may not reject an applicant for coverage unless the carrier mails a notice of rejection within 15 business days after the carrier's receipt of the applicant's properly completed questionnaire (and carrier's application documents). If notice of rejection of the applicant is not mailed within these 15 business days, the carrier may not refuse the applicant for coverage.

Carriers are not required to reject an applicant and may accept applicants who fail the health screen. However, carriers must apply the screen to their entire portfolio of individual plan offerings and may not approve coverage for one or some plans while denying access to other plans. In the case that a carrier accepts an applicant who fails the health screen, the carrier must tell the applicant that the applicant failed the screen but was accepted anyway.

Carriers will add information to the rejection notice so that the applicant will know specifically why the rejection occurred and what their score was. A copy of the scored questionnaire must be returned along with a WSHIP application, plan description and WSHIP appeal process information to all rejected applicants. WSHIP will supply these materials. WSHIP plan material can be ordered through the Administrator:

-- Outsourced Administrative Systems, Inc. (OASYS)
4550 Victory Lane
Indianapolis, IN 46203

Carriers must offer a direct appeal opportunity to rejected applicants. Applicants will also have an option to a WSHIP appeal. WSHIP appeal scope will be limited to the carrier's accurate application of the screening questionnaire tools, including appeals related to the proper timing of the rejection notice.

Scoring Instructions for the High-Risk Pool Questionnaire

WSHIP has provided a point based scoring tool to be used with the Standard Health Questionnaire. The scoring tool lists conditions by body system in the exact order as the questionnaire.

A second list of "Conditions Not on the Questionnaire" has been provided as part of the scoring tool. This list is to be used to score conditions applicants may write in the Questionnaire form.

For the following instructions "checked" conditions refer to conditions on the questionnaire for which the respondent indicates that he or she has been diagnosed.

1. If any one of the conditions from the "major" category (conditions 1–24) is checked, then the respondent may be rejected for coverage; no further scoring is needed for this respondent.
2. If at least one of the diabetes conditions (conditions 117) **and** hypertension (condition 71) are checked, then the respondent may be rejected for coverage; no further scoring is needed for this respondent.
3. For other checked conditions (conditions 25–269), record the corresponding score from the scoring system worksheet. If there are multiple responses for a single numbered condition, use the response that produces the highest score.
4. If there is no score listed in a "Diagnosed but not Treated" column in the scoring tool, use the score in the corresponding "Operated/Treated" column.
5. The situation frequently arises that two or more conditions may be mutually exclusive. No more than one of the conditions in such a set should be marked. The following list contains sets of conditions where, if more than one condition is marked within a set, score only the marked condition that has the highest point value.

44(a)-(c)60(a)-(b)68(a)-(c)69(a)-(b)73(a)-(c)76(a)-(c)104(a)-(c)116(a)-(b)117(a)-(d)123(a)-(c)126(a)-(e)161(a)-(c)165(a)-(b)167(a)-(d)176(a)-(d)178(a)-(b)181(a)-(b)183(a)-(b)188(a)-(b)
199(a)-(c)220(a)-(c)231(a)-(b)241(a)-(b)242(a)-(d)246(a)-(b)

6. "Write-in" conditions are not to be scored unless they specifically appear on the "Other Conditions Not on the Questionnaire" scoring list or elsewhere in the scoring tool. The only exception is if an applicant writes in a condition using a common name, which clearly is the same as a listed condition. If the respondent has provided additional conditions in any section of the questionnaire (write-in conditions) do not score them unless they appear on one of the two scoring sheets. Please contact the Washington State Health Insurance Pool if you believe the condition should be scored.
7. Use the respondents age (if juvenile only), weight (all respondents), and gender (adults only) to identify the appropriate score from the build charts.
8. Add up all recorded scores.
9. If the total score is 330 or greater, then the respondent may be rejected by the carrier and is eligible to enroll in the high-risk pool.

Clarifying Notes:

The following notes result from observations by users of the questionnaire form:

1. **Burns 3d Degree #151 & 152:** For these conditions only; the Operated/Treated score should be read as "Still under treatment". The Diagnosed but not treated score should be read as "Treatment Completed". The rationale is that if an individual had burns of these magnitudes, they would seek medical help.
2. **Juvenile Build Chart:** Height is expressed in two-inch intervals. If a child falls between the listed heights use the height that the child has attained. For example, a child who is 35 inches tall would be evaluated as 34 inches not 36 inches.

WSHIP Rejected

HOME :

log

[File Upload](#)[Data Entry](#)[View Data](#)[View Files Loaded](#)[Carrier Report](#)Washington State Health Insurance Risk Pool
Rejected Applicant Reporting

Please Choose:

- Data Entry : enter a single applicant to be reported to WSHIP
- File Upload : upload a fixed-field file for batch processing
- View Data : browse records in the WSHIP database. Click the applicant name for detail.

Search

GO ►

Please [Click Here](#) to e-mail technical support.

Fixed-field File format for upload

Field	Length
First Name	20
Middle Name	20
Last Name	20
Address 1	50
Address 2	50
City	30
State	2
Zip	10
Phone #	20
e-mail	75
Date of Birth (MMDDYYYY)	8
Primary First Name (opt)	20
Primary Middle Name (opt)	20
Primary Last Name (opt)	20
Sex (M/F)	1
Date Screened (MMDDYYYY)	8

WSHIP Rejected[HOME](#) :Data Entry


- [File Upload](#)
- ☒ [Data Entry](#)
- [View Data](#)
- [View Files Loaded](#)
- [Carrier Report](#)

[Back One level](#)

Search


 Rejected Application Data Entry

Primary First Name	<input type="text"/>
Primary Middle Name	<input type="text"/>
Primary Last Name	<input type="text"/>
First Name	<input type="text"/>
Middle Name	<input type="text"/>
Last Name	<input type="text"/>
Address1	<input type="text"/>
Address2	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Zip	<input type="text"/>
Phone	<input type="text"/>
e-mail	<input type="text"/>
Date of Birth (MMDDYYYY)	<input type="text"/>
Sex M/F	<input type="text"/>
Date Screened (MMDDYYYY)	<input type="text"/>

online  Powered by
Healthplan.com
a product of ACS Healthcare Solutions

WSHIP Rejected[HOME](#) :File Upload[login](#)**File Upload**[Data Entry](#)[View Data](#)[View Files Loaded](#)[Carrier Report](#)**Fixed-field File Loader** [Back One level](#)

Search

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This survey is sent to you by the Washington State Health Insurance Pool (WSHIP) because you were recently denied health coverage based on information gathered from the health screening questionnaire. WSHIP oversees the individual health insurance high-risk screening process in Washington State. Your feedback on the following survey will assist WSHIP with their efforts to offer affordable health insurance coverage to those individuals who are eligible. All information on this form will be kept strictly confidential.

1. Have You Purchased WSHIP Health Insurance Coverage ☐ Yes ☐ No

If you answered **NO**, please check all that apply:

- Did not know insurance was available through WSHIP ☐
 Did not understand how to apply to WSHIP ☐
 Applying to WSHIP is too much work ☐
 Applying to WSHIP is too confusing ☐
 WSHIP rates are too expensive ☐
 Do not need insurance coverage ☐

(if checked, please answer question 2 below)

Other (please explain) _____

2. Have You Already Enrolled in Insurance ☐ Yes ☐ No

If **YES**, are you enrolled in (check one):

- (a) I am enrolled in WSHIP ☐ Yes ☐ No
 (b) Another individual health insurance carrier ☐ Yes ☐ No
 (c) A family member's policy ☐ Yes ☐ No
 (d) Another state program (e.g. Medicaid or the Basic Health Plan) ☐ Yes ☐ No
 (e) A federal program like Medicare ☐ Yes ☐ No
 (f) A plan offered by my employer ☐ Yes ☐ No
 (g) Other (please explain) _____

3. I Remain Uninsured for Health Care ☐ Yes ☐ No

4. Other Information

☐ Male ☐ Female

Age: ☐ 18 – 30 ☐ 31 – 44 ☐ 45 – 64 ☐ 65 and over

Income: ☐ Under \$25K / yr ☐ \$25-50K / yr ☐ Over \$50K / yr

5. Do You Have Access to The Internet ☐ Yes ☐ No

6. If you need assistance with this survey, call **WSHIP** at **866.405.6148**. If you want information about other health insurance options, call the **Statewide Health Insurance Benefits Advisors (SHIBA)** at **800.397.4422**, TTY 360.664.3154.

7. Any Comments?

Thank you for your time. Please return the survey in the enclosed postage-paid envelope.

ATTACHMENT F

Do you have an insurance question or complaint? Call...

OIC Consumer Hotline:
1-800-562-6900

For free assistance with health insurance access and coverage, call...

SHIBA Helpline:
1-800-397-4422

News Center

Information for...

Consumers

Insurers

Agents/Brokers

**Insurance Laws
and Regulations**

Publications

Contact the OIC

Search This Site

**Go Back to the OIC
Home Page**



NAIC

Washington State Office of the Insurance Commissi

Options in the Individual Market

At a Glance: What the individual market is, what you can expect to pay, and how to buy

Navigating Health Care Coverage: A comprehensive consumer guide about health ca

- **Section 1:** Defining Your Needs and Eligibility
- **Section 2:** Gaining and Maintaining Control of Your Health Insurance

Frequently Asked Questions: Experts from the Office of the Insurance Commissioner the individual market.

A **separate fact sheet** compares the broad changes that are occurring under a new sta insurers to re-enter the individual market.

A **more detailed chart** explains those changes in depth.

Key Resources: Telephone numbers, web contacts, e-mails, and other help for shoppe

Counseling and Education: For additional information about the individual market, indi **HelpLine** at 1-800-397-4422 or the OIC Consumer Hot Line at 1-800-562-6900.

The Background:

Shopping for health insurance became inconvenient in Washington state's indivi two years, because the three largest health insurers in the state refused to sell n Legislature agreed to make changes to health-care reforms and consumer prote

The changes demanded by the carriers were passed by the 2000 session of the Some small regional carriers remained in the market in selected counties, but in carriers also reopened sales as they had promised. The new plans and rates we

The Major Changes:

Here are some of the significant changes in the Insurance Code that will affect ir

1. Many applicants for new coverage (but not all) will have to undergo a He identify the most costly 8% of the new applicants based on their health hi turn down those applicants, and those individuals' only recourse will be c State Health Insurance Pool (WSHIP). The Health Screen works like this whether they have or have not experienced conditions and treatments id Each condition is assigned a number of points, and applicants who accui points will pass the screen. The carrier may send the applicant with more WSHIP pool.

WSHIP Health Screen Questionnaire
WSHIP Health Screen Scoring

2. Who Will Be Health-Screened? The new law generally applies to anyone without previous coverage or anyone buying "richer" coverage than they

However, certain consumers will specifically NOT be required to undergc

include:

- People who have exhausted their COBRA coverage. This does not wait for their COBRA coverage to expire before applying to a new plan. Consumers should apply in advance, because the new coverage must be applied for 30 days.
- Medicare beneficiaries who are losing their managed care plans and need supplemental coverage to replace them.
- People who are seeking a different product because they are related to another.
- People whose current plan is being discontinued and replaced by a new plan.
- People who are applying for new coverage in order to stay with a current carrier.
- Federal law also will prevent others from having to undergo the health screen. Additional information on those concerns is available elsewhere at www.hcfa.gov/medicaid/hipaa

3. Cost: What you pay under the new rules will be affected by your age as well as your health. WSHIP is a high-risk pool whose rates will be significantly higher than the market average. In addition, the new law requires individual health insurers to provide drug and maternity coverage in the future. As a consequence, analysts expect to help cover the cost of those benefits. Finally, the law removes the ability of insurers to review rates in the individual market. That leaves the responsibility for rate increases to the carriers who will be able to increase rates at will. Companies will still have to file for rates but the state no longer can veto them.

Here is a [thumbnail comparison](#) of rates in the current market, according to the Office of the Insurance Commissioner. Note that discounts may reduce the rates an individual pays for WSHIP coverage will be discounted up to 15% off the pool or previous coverage in the private market for 18 months or more.

4. Carriers also will be able to enforce much longer waiting periods for coverage. The new law allows carriers to delay coverage for up to nine months for pre-existing conditions (or should have been treated) during the previous six months. They can challenge untreated pre-existing conditions on the ground that a reasonable person would have sought coverage.
5. Under the new law, carriers have to include solid maternity benefits and prescription drug coverage in new individual policies. Both maternity and prescription drug coverage were eliminated in the individual market in recent years.

Your Options:

Here are the key options for those seeking coverage in the individual market. They are detailed further down:

1. Individuals in counties where individual policies are not being sold will be able to buy from the Washington State Health Insurance Pool (WSHIP). Click on the "Guest" and then select "Washington State Health Insurance Pool" from the list. For more information, click here: <http://www.onlinehealthplan.com>
2. In counties where individual policies are available, coverage from WSHIP is available for a person who does not pass the individual health screen.
3. People who pass the health screen will be able to buy in the individual market. To find out who is selling individual plans in your area, contact the carrier.

Basic Health of Washington State	1-800-826-2444
Group Health Cooperative	1-800-358-8815

Kitsap Physicians Service	1-800-628-3753
Premiera Blue Cross,	1-800-PLAN-ONE (6)
LifeWise Health Plan of Washington	1-888-836-6135
Regence BlueShield of Washington	1-888-344-8234
Regence Blue Shield of Idaho	1-800-632-2022
Regence Blue Shield of Oregon/HMO Oregon	1-800-547-0939

- Washington State's Basic Health program, 1-800-826-2444, is available (qualify by income).
- For information on alternatives to the individual market such as group of people and solely-owned businesses and association or small group plan broker licensed to sell health insurance.

Individual Market at a Glance:

The Individual Health Insurance Market represents about 5 percent of Washington consumers. The vast majority of people with health insurance in the state and in employer benefit plans. But self-employed people and workers at very small companies health benefits must purchase their health coverage individually.

Many people in the individual market are transitional subscribers. People who cannot want to arrange individual coverage until they can return to an employer plan. Even coverage for several years before they can qualify for Medicare at age 65. Young people just getting started may need some type of health coverage before they get established benefits.

Traditionally, the national individual market has been one of the cheapest places to get health insurance because it has generally been a healthier market. But in recent years, health insurance costs have increased significantly. You can download premium tables for a snapshot comparison of face in today's market:

[Excel](#) // [HTML](#)

Individual Market Help for Consumers:

Office of the Insurance Commissioner Consumer Hot Line: 800-562-6900
www.insurance.wa.gov

Statewide Health Insurance Benefits Advisors (SHIBA) HelpLine 800-397-6666
www.insurance.wa.gov/shiba/default.asp

Basic Health 800-826-2444
www.wa.gov/hca

<http://www.wa.gov/hca/basichealth.htm>

Washington State Health Insurance Plan (WSHIP) 800-877-5187
Click on the following link, log on as a "Guest" and then select "Washington State Health Insurance Plan" from the menu to access this information. Click here:
<http://www.onlinehealthplan.com>

E-mail insurance@oic.wa.gov for complaints or questions.

[Contact SHIBA HelpLine](#)

The Board reviewed a draft of the decision criteria for allocating FCL discounts. Budget projections developed by the Basic Health Plan were also reviewed. Copies of both documents are attached to the meeting agenda.

It was moved and seconded that FCL discount policy be approved as recommended by the Process work group.

Motion passed 7 to 0

I was noted that the format of the final policy document should more clearly set out the decision criteria contained in the policy statement.

4. Questionnaire Process Work Group Recommendation: Carrier Reporting / WSHIP Outreach:

Under ESSB 6067, carriers are required to report to WSHIP information about applicants rejected for coverage. The Board reviewed a document outlining the data elements to be requested of carriers. After discussion, there was consensus that the basic data requested (with changes added) was appropriate.

The issues of obtaining additional data to support WSHIP's outreach and market evaluation efforts were referred to the Questionnaire Process Work Group. The Process Work Group was directed to make recommendations on reporting and outreach for review by the Board. The recommendation of the work group is attached to the meeting agenda.

It was moved and seconded to approve the Process Workgroup recommendations for carrier reporting and WSHIP outreach to health screened individuals. ←

Motion Passed 7 to 0

5. Review of WSHIP cash flow:

A cash flow projection was distributed for review. Based on current information, it appears that WSHIP will not need to make a second assessment of insurance carriers for operating funds in 2000. The Board at its February and March 2001 meetings will review assessment requirements for 2001.

6. Benefit and rate notice mailing.

Mr. Denning outlined the process for mailing letters to WSHIP enrollees advising them of benefit changes and rate discounts approved by the Board for 2001. The changes are effective January 1, 2001. The mailing is scheduled for the week of December 18, 2000.

Note: During the course of his report, Mr. Denning stated that the Board had made a decision regarding "runout" of maternity benefits for current enrollees losing WSHIP coverage as a result of ESSB 6067 eligibility changes. On review after the meeting adjourned, Mr. Denning amended his statement. The Board decision had been to waive new PEC wait requirements for people enrolled in WSHIP as of December 31. WSHIP eligibility had not been addressed.

An emergency telephone conference meeting of the Board was held on December 14, 2000. During that meeting, the Board decided that the mailing to enrollees in December should not address ESSB 6067 eligibility

WSHIP Application Statistics
OIC Response

	Jan-01	Feb-01	Mar-01	Apr-01	May-01	Jun-01	Jul-01	Aug-01	Sep-01	Oct-01	Nov-01	Dec-01	2001 Total
New Applications Received	115	97	115	117	90	111	98	77	87	124	84	109	1,224
Applications Pending @ Month End	163	135	154	0	146	155	166	145	111	134	143	177	1,629
Rejects, Withdrawn, & Closed	187	134	191	236	142	25	58	65	79	72	117	64	1,370
Applications Approved	113	66	71	64	126	38	91	87	73	81	80	70	960
Unprocessed Applications on Hand	0	0	0	0	0	0	0	0	0	0	0	0	0

	Jan-02	Feb-02	Mar-02	Apr-02	May-02	Jun-02	2002 Total	Average
New Applications Received	114	91	99	102	106	117	629	105
Applications Pending @ Month End	174	150	170	115	156	156	921	154
Rejects, Withdrawn, & Closed	68	62	55	69	13	11	278	46
Applications Approved	90	84	83	96	95	83	531	89
Unprocessed Applications on Hand	0	0	0	0	0	0	0	0

1/01 - 6/02	Total	Average
New Applications Received	1,863	103
Applications Pending @ Month End	2,550	142
Rejects, Withdrawn, & Closed	1,648	92
Applications Approved	1,491	83
Unprocessed Applications on Hand	0	0

ATTACHMENT H

Average	
102	New Applications Received
136	Applications Pending @ Month End
114	Rejects, Withdrawn, & Closed
80	Applications Approved
0	Unprocessed Applications on Hand

	New Applications Received
	Applications Pending @ Month End
	Rejects, Withdrawn, & Closed
	Applications Approved
	Unprocessed Applications on Hand

	New Applications Received
	Applications Pending @ Month End
	Rejects, Withdrawn, & Closed
	Applications Approved
	Unprocessed Applications on Hand

WASHINGTON STATE HEALTH INSURANCE POOL
(WSHIP)

APPLICATION CHECKLIST



- ☐ Is your application completely filled out and signed in black ink?
- ☐ Did you choose a health care plan (Plan 1 or Plan 3)? **See Section I. Please Note:** Changing Plans can only be done effective January 1st each year. (Exceptions may be made, upon review, under special circumstances.) If you are eligible for Medicare, you must use the WSHIP Medicare plan application. Contact WSHIP for that application.
- ☐ If you have a post office box, is a street address also included? **See Section II.**
- ☐ Have you included proof of Washington residency? **See Section III.**
- ☐ Did you check an eligibility category? Did you include a copy of the documentation asked for under the category you checked? Notice of rejection must be on insurance carrier letterhead, signed by an underwriter, addressed to the applicant and be due to the applicant's health. A copy of the scoring page from the WSHIP Standard Health Questionnaire returned to you by the insurance carrier may be used for this purpose. **See Section III.**
- ☐ Did you identify any other health care coverage in effect? **See Section IV.**
- ☐ If the Pre-existing Waiver Benefit applied to you, did you include a Certificate of Creditable Coverage from your previous insurance carrier / employer? If your previous coverage was an individual plan, did you include a Summary of Benefits? **See Section V.**
- ☐ Did you sign the Disclosure Certification? **See Section VI.**
- ☐ Did you identify a premium payment cycle (Monthly Bank Draft, Quarterly, Semi-Annual or Annual)? **See Section VII.**
- ☐ Have you included the premium payment due according to the payment cycle chosen? **See Section VII. NOTE: If you are applying for the low income discount, you first must pay the amount due for one month's premium in order to activate your coverage.** ←
- ☐ If you chose the Monthly Bank Draft premium payment cycle, did you include one month's premium? Did you complete, sign and enclose the Authorization Agreement for Automatic Withdrawal? Did you attach a voided check? **See Authorization Form.**

If you have any questions about any of the above information or completing the application, please contact our customer service department via e-mail at www.onlinehealthplan.com® or by telephone at 1.800.877.5187.

All necessary information must be included and appropriate documentation attached when requested in order for application to be processed. An incomplete application will delay the approval process.

WASHINGTON STATE HEALTH INSURANCE POOL

Rates Effective January 1, 2003
Non-Medicare Plans

Basic Rates

Standard Plan Table 1-A				Network Plan Table 3-A		
Age	\$500 Deductible	\$1,000 Deductible	\$1,500 Deductible	Age	\$500 Deductible	\$1,000 Deductible
Child	\$206.67	\$180.47	\$152.28	Child	\$172.23	\$150.39
<25	\$270.51	\$239.40	\$216.11	<25	\$225.43	\$199.50
25-29	\$294.71	\$260.54	\$235.64	25-29	\$245.59	\$217.11
30-34	\$347.13	\$305.48	\$277.53	30-34	\$289.28	\$254.56
35-39	\$385.64	\$338.99	\$302.22	35-39	\$321.36	\$282.49
40-44	\$502.94	\$443.25	\$381.66	40-44	\$419.11	\$369.38
45-49	\$589.80	\$519.77	\$432.41	45-49	\$491.50	\$433.14
50-54	\$677.45	\$597.68	\$495.21	50-54	\$564.54	\$498.06
55-59	\$819.42	\$722.81	\$594.05	55-59	\$682.85	\$602.34
60-64	\$970.92	\$856.52	\$709.89	60-64	\$809.10	\$713.76
65+	\$970.92	\$856.52	\$764.97	65+	\$809.10	\$713.76

→ You Must Apply and be Approved to Qualify for the Low Income Discounts Below
(Ages 50-64 only and only if state funds are available)

Less than 251% of Federal Poverty Level

Age	\$500 Deductible	\$1,000 Deductible	\$1,500 Deductible	Age	\$500 Deductible	\$1,000 Deductible
50-54	\$496.79*	\$438.30*	\$363.15*	50-54	\$496.79*	\$438.30*
55-59	\$600.91*	\$530.06*	\$435.63*	55-59	\$600.91*	\$530.06*
60-64	\$712.01*	\$628.11*	\$520.59*	60-64	\$712.01*	\$628.11*

Greater than 250% and less than 301% of Federal Poverty Level

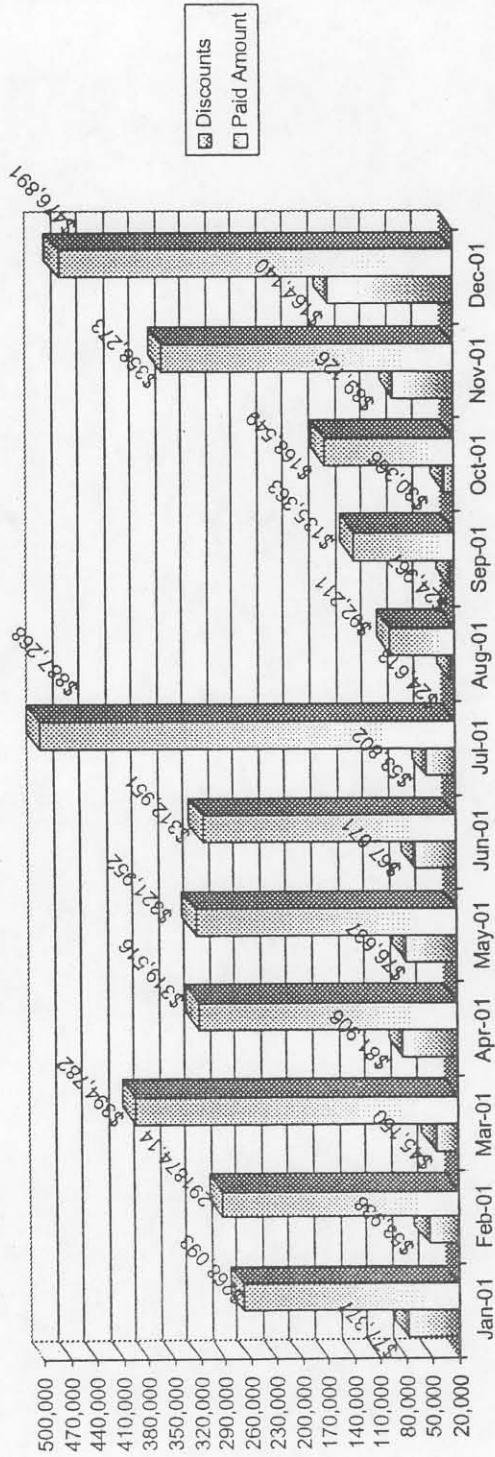
Age	\$500 Deductible	\$1,000 Deductible	\$1,500 Deductible	Age	\$500 Deductible	\$1,000 Deductible
50-54	\$575.83	\$508.03	\$420.93	50-54	\$496.79*	\$438.30*
55-59	\$696.51	\$614.39	\$504.94	55-59	\$600.91*	\$530.06*
60-64	\$825.28	\$728.04	\$603.41	60-64	\$712.01*	\$628.11*

*Indicates that rate is 110% of standard risk rate

Information and premium rates contained herein are subject to change without notice.

The total provider discounts in 2001 were \$789,092.

Provider Discounts - PPO Plans





HcS - HPDV	OASYS
CLM-012	02-01-2001
N/A	Page 1 of 5

ATTACHMENT L

High Dollar Claims

Department

Claims, Compliance

Purpose

To ensure the proper auditing of all High Dollar Claims. To make certain that only those services covered by the plan document, medically necessary, and medically appropriate are reimbursed.

Definitions

High Dollar Claims are described by account and type below:

USDOS and Peace Corps

Claims < \$10,000, Processor Reviews and Releases

Claims = / > \$10,000 Senior Quality Assurance Auditor Audits, Appropriate Staff Level (as noted below for Physician Claims) Releases

Kentucky

Claims < \$10,000, Processor Reviews and Releases

Claims = / > \$50,000 Senior Quality Assurance Auditor Audits, Appropriate Staff Level (as noted below for Physician Claims) Releases

All Other Accounts

Physician Claims < \$10,000, Processor Reviews and Releases

Physician Claims = / > \$10,000 and < \$50,000, Supervisor Reviews and Releases

Physician Claims = / > \$50,000 and < \$75,000, Manager Reviews and Releases

Physician Claims = / > \$75,000, Senior Quality Assurance Auditor Audits, Director Releases

Hospital-Outpatient Claims < \$25,000, Processor Reviews and Releases

Hospital-Outpatient Claims = / > \$25,000 and < \$50,000, Supervisor Reviews and Releases

Hospital-Outpatient Claims = / > \$50,000 and < \$75,000, Manager Reviews and Releases

Hospital-Outpatient Claims = / > \$75,000, Senior Quality Assurance Auditor Audits, Director Releases

Hospital-Inpatient Claims < \$25,000, Processor Reviews and Releases

Hospital-Inpatient Claims = / > \$25,000 and < \$50,000, Supervisor Reviews and Releases

Hospital-Inpatient Claims = / > \$50,000 and < \$75,000, Manager Reviews and Releases

Hospital-Inpatient Claims = / > \$75,000, Senior Quality Assurance Auditor Audits, Director Releases



Contract	HcS - HPDV	Contract	OASYS
Contract	CLM-012	Contract	02-01-2001
Contract	N/A	Contract	Page 3 of 5

Task(s)	Responsible Party	Reviewer
<ul style="list-style-type: none"> Interim/Continuing Bill – Applies only to inpatient claims. Prior \$ Paid – Applies only to interim or continuing bills. Surgical Procedure(s) – Written out. DRG Verified – Verify weight (1234000-005) and multiply by current base rate on OHP. Case Rate/Per Diem Verified Is Diagnosis Excluded – Check contract online. Is Procedure Excluded – Check contract online. Total Charges – Total charges being billed. Total Payment – Total dollars being paid. Today's Date Age of Claim Claims Analyst – Your signature to verify you have checked and verified all appropriate information. Use current date. Date 		
<p>Create an ISF (attach the appropriate claim and form), choose the subject of "Medical Management", complete the member number and region with the appropriate information, Reg/Acc should reflect "29" (KY ACCESS), check the broad category of "Medical Management" and the specific category of "other". The text box should reflect "High Dollar Claim", include any other extreme charge or item you believe should be reviewed.</p> <p>If multiple surgeries involved, give detail on which procedure is primary, secondary, tertiary, etc.</p>	Claims Analyst	QA Analyst
Send action gram to appropriate Medical Review Analyst.	Claims Analyst	QA Analyst
Review high dollar ISF completed by Claims Analyst for medical information.	Medical Review Analyst	QA Analyst
Review claim for medical necessity, appropriateness of service and/or length of stay.	Medical Review Analyst	QA Analyst



System	HcS - HPDV	System	OASYS
Form	CLM-012	Form	02-01-2001
Signature	N/A	Page	Page 5 of 5

Task(s)	Responsible Party	Reviewer
Review claim and ISF for accuracy, and all appropriate reviews.	Unit Director	QA Analyst
Release claim and return ISF.	Unit Director	QA Analyst

Performance Standards

All High Dollar Claims audits will be performed in a timely manner, where "timely" is defined as ensuring that the account is in compliance with any contractual and/or regulatory standard.

Submitted By:

Name: Ann Bingman

Title: Client Accounting and Contract Compliance Director

Signature: _____

Date: _____

Approval: Gary Ries

Title: Director and General Manager Outsourcing Operations

Signature: _____

Date: _____

Document Information -

Author	Linda Looney	Date Published	2-1-2001	Archive Date	
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Revision Information -

Author	Date	Revision Comments
Linda Looney	6-1-2001	Existing policy was modified into new template format.
Ann Bingman	11-19-2001	Modified definitions of High Dollar Claims.
Jacki Anderson	6/21/02	Changed logo.
Cathy Taylor	6-30-03	Modified Procedures.

☒ Credit Memo☐ Debit MemoAmount \$ \$1,208.00

(Check one box)

☐ Issue on next invoice☒ Issue against AR

Invoice #

15109413

Amount

\$

\$1,208.00

Invoice #

Amount

\$

Customer Name:

WSHIP

Business Unit/Region:

State 2

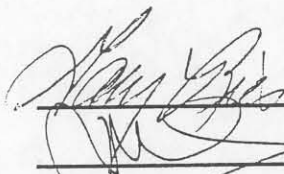

Month in which issue occurred:

September

Requested By:

Linda LooneyReason for Credit: SLA missed

Approved by

Date

10.11.02

Approved by

Date

10.11.02

Finance Approval

Date

Complete for SLA Penalty's Only

Service Level Missed (describe the measure & ACS' requirement)

Claims timeliness SLA is 90% in 15 days and we only paid 86% in 15 days.

Problem Encountered (describe the problem & root cause)

Open data entry (vertexing) position has now been filled

Penalty Assessment (show calculations as per agreement)

 $\$.50 \text{ ppm} \times 2416 = \1208.00

SOLVE Ticket Numbers (where applicable, give the ticket numbers)

Root -

Y/N

Approvals Required (initial & date)

Regional VP/SVP

Henry Hortonstine

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ATTACHMENT C

Group	HcS - HPDV	Location	OASYS
Policy	CMP-006	Effective Date	12-17-2001
Revision	N/A	Page	Page 1 of 2

Procedures to Audit Customer Service Representatives (CSRS)

Department

Compliance

Purpose

To ensure the accuracy and timeliness of the Customer Service Representatives, as specified in the contracts or internal OASYS performance standards.

Policy

To perform monthly audits of Customer Service Representatives and ensure compliance with contractual and/or regulatory guidelines. Additionally, quality is monitored for employee performance evaluations.

Procedure

Task(s)	Responsible Party	Reviewer
<ul style="list-style-type: none"> Access the employee's phone extension through the BCMS System. Listen to the phone inquiry. 	Q A Analyst	Compliance Analyst
<ul style="list-style-type: none"> Review the Customer Service Representative phone inquiry documentation for accuracy and timeliness, by referring to the account policies and procedures. 	Q A Analyst	Compliance Analyst
<ul style="list-style-type: none"> Use the CSR Quality Review Spreadsheet to document the audit, referring to the CSR Audit Base Model Legend. List all comments and a description of errors. Place completed audits in employee's file. 	Q A Analyst	Compliance Analyst

CSR Audit Workflow

A. BCMS Phone System

- 1) Log into the BCMS System, using the designated button on the QA Analyst phone and CSR extension.
- 2) Listen to the phone inquiry. Calls that do not require a CSF are: request for fax numbers, internet or mailing addresses, telephone numbers, and internal transfer calls.
- 3) Document telephone accuracy. [Checked for duplicate. If duplicate of inquiry found, was existing CSF amended or notes added. Technique (identified self and client) and compliance with HIPPA (authenticated caller-verified date of birth.) Refer to CSR Quality Review Spreadsheet located at W:\Compliance.
- 4) Refer to the CSR Quality Review Legend (located on same drive and folder) for audit guidance located at W:\Compliance.
- 5) List all comments and description of errors.

B. Macess

- 1) Access Macess to retrieve Customer Service Form completed by CSR for documentation:
 - a) Click on Imax Live Folder on desktop.
 - b) Click Imax Live shortcut.
 - c) Enter Logon ID and Password.
 - d) Welcome box will appear up with any information for you, enter.
 - e) Will receive two error boxes, enter through both.
 - f) Click on Out Box using Imax Menu.
 - g) Drop down box will appear, select Create Contact Service Form.
 - h) Another drop down box will show, select Government Contact Service Form. (Form is yellow.)
 - i) Input Member ID Number, including suffix and ending with region code. (For example, 12345678900IC.)
 - j) Click on chevrons next to Member ID Number to open folder.
 - k) Click on drop down box, select Contact Service Forms.
 - l) Double click on the CSF you want to view.
- 2) The following fields require auditing:
 - a) Member # + Region - Identification number with suffix and 2 digit region code.
 - b) Provider # + Region - Tax ID Number with 2 digit suffix and region code (if applicable).
 - c) Caller - First and last name of actual contactor.
 - d) Phone - Telephone number of contactor, including area code.
 - e) Subject - Brief description for reason of contact.
 - f) Contactor - Type of person who is making contact.
 - g) Contact - Method by which the contact is made.
 - h) Region and/or Account - Area that the call relates to.
 - i) Broad Category - Reason for contact.

CSR Quality Review Legend

STANDARD

REASONS FOR N/A RATING

ERROR TYPE AND RATING

Macess Accuracy

A CSF is not required for requests such as fax numbers, website and mailing addresses, phone numbers, internal transfers, and wrong identification numbers. While they are also not required for callers that cannot be authenticated, all audited calls must be able to be authenticated so this should not be used as a reason. If there is already a CSF in the Member's folder related to the same issue, only the notes section should be updated.

Loaded Phone Call to Macess Within Correct Time Frame

"0" or "5"

Used Correct Codes

If amending an existing Service Form.

"5" if perfect; "4" if missed 1 or 2 codes; "2" if missed 3 or 4 codes.

Entered Accurate Responses

None

"0" or "5"

Completed All Appropriate Fields Accurately

If amending an existing Service Form.

"5" if no errors; "4" if missed 1 or 2 fields; "2" if missed 3 or 4 fields.

Sent Action Gram, When Necessary

If amending an existing Service Form. If action is not required.

"0" or "5"

HIPAA

Authenticated Caller

None

"0" or "5"

Confirmed Business Purpose (Need to Know)

None

"0" or "5"

Applied Minimum Necessary

None

"0" or "5"

Date: _____

Audit # _____

CSR Audit Checklist

Account _____

CSR Name _____

Tax ID # _____

Caller Name _____

Member Name _____

Member ID# _____

Answered Phone Appropriately YES ☐ NO ☐

Identify Caller Name: YES ☐ NO ☐

_____/_____/_____
Date of Birth - HIPAA YES ☐ NO ☐

Phone Number YES ☐ NO ☐

Disclaimer YES ☐ NO ☐ N/A ☐

Understood Request
And Took Correct Action YES ☐ NO ☐

Loaded Call To Macess YES ☐ NO ☐

Used Correct Codes YES ☐ NO ☐

Accurate Responses Entered YES ☐ NO ☐

Fields Completed Accurately YES ☐ NO ☐

Sent ActionGram if Needed YES ☐ NO ☐ N/A ☐

Comments



System	HcS - HPDV	Location	OASYS
Transaction	ADJ-001	Effective Date	12-22-00
Version	N/A	Page	Page 2 of 4

Task(s)	Responsible Party	Reviewer
<p>To post the refund go to screen 145 6800.002</p> <ul style="list-style-type: none"> • Enter an "R" in the Action Field • Enter a "C" in the payment source • Enter the Payee Number (provider's ID number) when payee is "2" this number should be in the member's ID number • Press "Enter" and the Payee Name automatically displays • Enter the refund check number • Enter the dollar amount of refund (NOTE: If you have one check for multiple claims you will need to split posting. Only enter the money from this check for the appropriate claim) • The "Transaction Date" fills in automatically • Enter the refund reason code (see list below) • Press "Enter" • Some claims may or may not display at the bottom of your screen 	Adjuster	Q/A Analyst
If your correct claim number is displayed, enter the appropriate sequence number that matches the claim under "Enter seq.#".	Adjuster	Q/A Analyst
If your claim number does not display at the bottom of the screen, enter "88" in the sequence # box. A prompt "NO other transaction records-performs surplus processing (Y/N)?" will appear. Type "Y" for yes and press, "enter".	Adjuster	Q/A Analyst
A prompt "non-solicited refund check (Y/N): will appear. Type "Y" for yes and press, "enter".	Adjuster	Q/A Analyst
Then type in the claim number and the line the claim paid on (example: 010). The system will automatically enter the refund amount. If you receive a prompt "Payment on line does not match the refund amount", back out the dollars in the amount applied and type the amount to post. When you are finished posting the money, the "Amount to distribute" field should read all zeros.	Adjuster	Q/A Analyst
<ul style="list-style-type: none"> • Enter refund received and posted to the data base • Click on Refund.exe • Enter username and password • Click on "Main" • Click on "Find Next" to the patient I.D.# [This should pull up all refund request on this member] • Match to your refund and enter the refund check #, amount received, post date • Click on "Save" [the disk at the top] 	Adjuster	Q/A Analyst



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ADJ-001	12-22-00
N/A	Page 4 of 4

Submitted By:

Name: Rochelle Webber

Title: Claims Specialist

Signature: _____

Date: _____

Approval: Gary Ries

Title: Director and General Manager Outsourcing Operations

Signature: _____

Date: _____

Document Information -

Author	Rochelle Webber	Date Published	12/22/00	Archive Date	
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Revision Information -

Author	Date	Revision Comments
Carol Baker	6/1/01	Reformatted existing policy into template.
Jacki Anderson	6/21/02	Changed Logo



HcS - HPDV	OASYS
ADJ-002	12-22-00
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Task(s)	Responsible Party	Reviewer
<p>To request a refund, set-up an ISF (Internal Service Form) in MACESS</p> <ul style="list-style-type: none"> Under subject type in "Refund Request" and the claim number associated with the refund Enter member ID number, regular account number Click on "Claims/Other" Enter reason for the refund in the blank box located in the middle of the page (see codes below) Click on "Follow-up" Click on "Create Form Letter" Complete letter by filling in the necessary areas 	Adjuster	Q/A Analyst
<ul style="list-style-type: none"> Print and save the letter to member's folder Exit the letter Click on "Cancel to exit follow-up box" Click on "File" Click on "Completed" Click on "Save Changes" Click on "Cancel to exit the ISF" 	Adjuster	Q/A Analyst
<p>Log refund request in the refund database</p> <ul style="list-style-type: none"> Go to "Refund Database" located on desktop Click on "Refund.exe" Enter user name and password Click on "Main" Click on the large arrow "→" Enter appropriate information in fields <ul style="list-style-type: none"> Pt. ID Provider ID Provider Name Account Claim # Date of Service (00/00/00) Ck # (the check that we issued) Date Paid Status [OPEN] Reason Amount Requested Request Date Click on "Save" [Disk at the top] 	Adjuster	Q/A Analyst
Place refund letter for mailing in the ""outgoing" mailbox in the mailroom.	Adjuster	Q/A Analyst



HcS - HPDV	OASYS
ADJ-002	12-22-00
N/A	Page 4 of 4

Submitted By:

Name: Rochelle Webber

Title: Claims Specialist

Signature: _____

Date: _____

Approval: Gary Ries

Title: Director and General Manager Outsourcing Operations

Signature: _____

Date: _____

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Revision Information –

Author	Date	Revision Comments
Carol Baker	6/1/01	Reformatted existing policy into template.
Jacki Anderson	6/21/02	Changed logo.

CSR Quality Review

ID _____

Name _____

Standard	Percent Possible	Scale	Percent Scored	Comments
Telephone Accuracy				
Identified Caller Name	5%	5% 4% 3% 2% 0%		
Understood Request and Used Appropriate Resources and Research	5%			
Responded Accurately and Completely	5%	N/A		
Used Disclaimer	5%			
Validated Inquiry is < 10 Days	25%			
Telephone Technique				
Used Professional Speech	5%			
Identified Self and Client	5%			
Asked for Appropriate Information	5%			
Managed Call	5%			
Displayed Courtesy and Empathy	25%			
Macess Accuracy				
Loaded Phone Call to Macess Within Correct Time Frame	5%	5% 4% 2% 0%		
Used Correct Codes	5%			
Entered Accurate Responses	5%	5% 4% 2% 0%		
Completed All Appropriate Fields Accurately	5%	N/A		
Sent Action Gram, When Necessary	25%			
HIPAA				
Authenticated Caller	5%			
Confirmed Business Purpose (Need to Know)	5%			
Applied Minimum Necessary	15%			
BCMS Ranking				
ACD Calls	5%	5% 4% 3% 2% 1% N/A		
Average Talk Time	10%	5% 4% 3% 2% 1% N/A		
Total Points				
	100%			